CONTRACT SUMMARY SHEET

RFS Number:	318.65-128	**Contract Number:**	FA-04-15757-03
State Agency:	Department of Finance and Administration	**Division:**	Bureau of TennCare

Contractor	**Contractor Identification Number**	
First Health Services Corporation	X V- C-	540849793 03

Service Description

Point of Sale (POS) Pharmacy Claims Processing and Preferred Drug List Development and Management

Contract Begin Date	**Contract End Date**
January 1, 2004	December 31, 2006

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.65	073	134	11	X on STARS		

FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)
2004	$1,453,500.00	$1,453,500.00			$2,907,000.00
2005	$4,757,822.00	$4,757,822.00			$9,515,644.00
2006	$8,487,366.00	$8,487,366.00			$16,974,732.00
2007	$4,251,312.00	$4,251,312.00			$8,502,624.00
Total:	**$18,950,000.00**	**$18,950,000.00**			**$37,900,000.00**

CFDA #	93.778 Department of Health & Human Services Title XIX

State Fiscal Contact

Name:	Scott Pierce
Address:	310 Great Circle Road Nashville, TN
Phone:	(615) 507-6415

Procuring Agency Budget Officer Approval Signature

Check the box ONLY if the answer is YES:	
Is the Contractor a SUBRECIPIENT? (per OMB A-133)	
Is the Contractor a VENDOR? (per OMB A-133)	x
Is the Fiscal Year Funding STRICTLY LIMITED?	
Is the Contractor on STARS?	x
Is the Contractor's FORM W-9 ATTACHED?	
Is the Contractors Form W-9 Filed with Accounts?	x

COMPLETE FOR ALL AMENDMENTS (only)

	Base Contract & Prior Amendments	This Amendment ONLY
END DATE →	12/31/2006	
FY: 2004	$2,907,000.00	
FY: 2005	$9,515,644.00	
FY: 2006	$16,974,732.00	
FY: 2007	$8,502,624.00	
FY:		
Total:	$37,900,000.00	0

Funding Certification

Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

RECEIVED
MAR 27 2006
DIRECTOR OF ACCOUNTS

IN WITNESS WHEREOF:

FIRST HEALTH SERVICES CORPORATION:

Teresa R. DiMarco, President — Date: 3/1/06

DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE:

M. D. Goetz, Jr., Commissioner — Date: 3/8/06

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr., Commissioner — Date: 3/21/06

COMPTROLLER OF THE TREASURY:

John G. Morgan, Comptroller of the Treasury — Date: 3/23/06

AMENDMENT THREE TO FA 04-15757-00
THE CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
BUREAU OF TENNCARE
AND
FIRST HEALTH SERVICES CORPORATION

This Amendment, by and between the State of Tennessee, Department of Finance and Administration, TennCare Bureau hereinafter referred to as the "State" or "TennCare" and First Health Services Corporation, hereinafter referred to as the "Contractor," is for the provision of Pharmacy Management and Preferred Drug List Services, as further defined in the "SCOPE OF SERVICES" is amended as follows:

WHEREAS, this Amendment shall reflect the changes to the TennCare pharmacy benefits program as required by the federal orders of *Grier Revised Consent Decree (Modified)* of August 3 and August 9, 2005.

1. Delete Section A.1.1 in its entirety and replace with the following:

A.1.1 Program Enhancements

Effective upon signature of this Amendment, the Contractor shall begin implementation of Program Enhancements and/or changes as directed by TennCare and as provided herein. Implementation shall be in three phases, Phase I, Phase II and Phase III. The start date for each phase is either (1) a date certain as shown on the chart below or (2) a number of days (as specified herein) after written notification by TennCare to the Contractor. The Program Enhancements in each Phase are set out below, including implementation deadlines. Many of these enhancements will result in telephone calls to the First Health Call Center. The Contractor agrees to staff the call center which is required under the Contract and operate it in accordance with the standards as required by Sections A.3.5.1 to A.3.5.3. Upon signature of this Amendment and as these enhancements become operational, TennCare agrees to compensate the Contractor for calls as outlined in Attachment B. The Contractor acknowledges that calls related to the preferred drug list ("PDL") are covered under the base contract and will not be reimbursed at the rates noted in Attachment B. The Contractor will assure that TennCare is not billed for such PDL-related calls and will submit monthly reports to TennCare detailing the numbers of resolutions associated with the PDL as well as the number of non-PDL related resolutions by edit and by type (technician, pharmacist or physician). Further the Contractor may not bill TennCare for any calls that are the result of an error or omission on their part in administration of the pharmacy benefit, including errors or omissions in the implementation of an edit. The above prohibition on the Contractor's billing for PDL calls and other PDL-related calls does not apply to Member-initiated prior authorization calls as provided for in Section C of this Contract.

Within thirty (30) days of signature of Amendment No. 2, the Contractor and TennCare shall conduct a requirements session to develop a report format for TennCare review and approval. Said report shall be designed to provide TennCare with monthly updates regarding the cost savings attributed to each Program Enhancement included in this Amendment. Following TennCare approval of the report format, said report shall be generated monthly and posted in First Decision.

Additional payment as agreed to by the Parties and as provided in this Amendment and Amendment No. 2 is the complete and whole compensation for implementation of the types of edits and services listed in the chart below. TennCare shall not pay additional implementation or pre-operational compensation in the event that additional, related edits are needed and which are reasonable, actual and necessary for the TennCare program,

Failure to meet deadlines as required herein, failure to provide reports or failure to implement Program Enhancements as required herein may result in liquidated damages and/or Breach by Contractor and are subject to remedies as provided in Section E.4. of the Contract. Prior to assessment of the damages provided in Section E.4, the parties agree to discuss the pertinent issues and make a determination as to the reason or responsibility for the failure to meet the deadlines as required or failure to implement Program Enhancements as required. If there is a failure by TennCare which directly contributes to the failure by the Contractor to meet deadlines or provide reports, TennCare agrees that that will be a major consideration in assessing responsibility.

Phase I Implementation

PROJECT	SUB-PROJECT	DATE PROJECT TO BEGIN	DATE TO COMPLETE IMPLEMENTATION
Script Limit Edits (see Contract Section A.2.2.3(i))	N/A	Upon signature of this Contract Amendment Two	No later than August 1, 2005
Tiered Co-Pay Edits (see Contract Section A.2.2.4(c))	N/A	Upon signature of this Contract Amendment Two	No later than August 1, 2005
Over-the-Counter Drug Coverage Elimination	N/A	Upon signature of this Contract Amendment Two	No later than August 1, 2005
Step Therapy		Upon signature of this Contract Amendment Two	No later than May 1, 2005
Administrative Edits	Gross Amount Due Edit	Already Implemented	Already Implemented
	Drug to Gender Edit	Already Implemented	Already Implemented
	Maximum Dollar Amount Edit	Already Implemented	Already Implemented
	DEA Number Edits	Already Implemented	Already Implemented
Clinical Edits	Drug Duplication of Therapy Edit (see Contract Section A.2.2.9(a)(ii))	Upon signature of this Contract Amendment Two	Phased in beginning in March of 2005
	Drug Dosage & Dose Optimization Edit	Upon signature of this Contract Amendment Two	Phased in beginning in March of 2005
Additional Dedicated Staff	(1) Clinical Pharmacist based in Nashville	Upon signature of this Contract Amendment Two	No later than August 1, 2005
	(2) Provider Educator	Upon signature of this Contract	(1) By May 1, 2005 (2) TBD

	Pharmacists based in Nashville	Amendment Two	
	(1) Pharmacy Research Scientist based in Nashville	Upon signature of this Contract Amendment Two	No later than May 16, 2005
	(1) Data Quality Analyst based in Nashville	Upon signature of this Contract Amendment Two	No later than July 1, 2005
	(1) Systems Liaison based in Richmond	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(1) Contract Manager based in Richmond	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(1) Business Analyst based in Richmond	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(1) "Reform" Project Manager based 25% in Nashville, balance in Richmond	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(2) Mail Room Clerks	Upon signature if this Contract Amendment Two	No later than May 1, 2005
Retro Dur	N/A	Upon signature of this Contract Amendment Two	No later than May 1, 2005

Phase II Implementation

PROJECT	SUB-PROJECT	DATE PROJECT TO BEGIN	DATE TO COMPLETE IMPLEMENTATION
Administrative Edits	Unit of Measure Edit	Upon written notification from TennCare	The latter of July 1, 2005 or sixty (60) days following written notification from TennCare
	MAC/DAW Edit	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare
MAC	N/A	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare

Phase III Implementation

PROJECT	SUB-PROJECT	DATE PROJECT TO BEGIN	DATE TO COMPLETE IMPLEMENTATION
Administrative Edits	Prescriber Last Name Edit	Upon written notification from TennCare	The latter of July 1, 2005 or sixty (60) days following written notification from TennCare
Clinical Edits	Drug Duration Edit	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare
	Drug-to-Disease Edit (see Contract Section A.2.2.9(a)(iii))	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare
	Drug-Drug Interaction Edit (see Contract Sections A.2.2.9(a)(iv) and A.2.2.9(a)(v))	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare

2. Delete Section A.2.2.3.p. in its entirety and replace with the following:

p. Phase I shall include the following edits:

Script Limit Edit
This claim limit restricts the maximum number of claims per month that certain, specified recipients can receive under the TennCare benefit. A "hard" limit restricts dispensing to the specified limit with the exception of drugs included on a shortlist developed by TennCare. TennCare shall transmit eligibility/enrollment information to the Contractor via the standard HIPAA 834 transaction, as defined by the TennCare Companion Guide. The Contractor must use this information to immediately (no more than two (2) business days) identify those enrollees who have no limits, have no pharmacy benefit, or are subject to limits, and make necessary systems changes to process claims accordingly. The NCPDP 1.1 formats must be used for encounter reporting sent to TennCare.

The Contractor shall send and individualized notice to the enrollee when the benefit limit has been reached and when prior authorization has been denied. The Contractor shall implement the following process at a date to be agreed upon between the Contractor and TennCare:

1. First Health Services shall generate, and forward to an outside vendor, an extract three times weekly in order to letter recipients regarding claims denied for the Script Limit edit. The extract will be inclusive of claims that have received the initial denial for exceeding the limit of five scripts per month and/or two brand name scripts per month. (Note: Recipients will receive a maximum of two letters monthly, related to the maximum of five scripts monthly and/or the maximum of two brand scripts monthly.)

2. These letters will be mailed on Monday, Wednesday and Friday of each week. Monday mailings will include letters based on claims denied on Friday, Saturday, and Sunday. Wednesday mailing will include letters based on claims denied Monday and Tuesday. Friday mailings mailing will include letters based on claims denied Wednesday and Thursday.
3. Recipients will receive a maximum of two letters monthly, related to the maximum of five scripts monthly and/or the maximum of two brand scripts monthly. If two letters are generated in an extract for the same mailing, they will be mailed as two separate pieces of mail.
4. TennCare will draft each of the two possible recipient Script Limit denial letters for submission to First Health Services.
5. Recipient letters will be generated on TennCare letterhead.
6. The return address on recipient letter mailing envelopes will be identical to that on mailing envelopes for recipient ID cards.

   TennCare Pharmacy Program
   c/o First Health Services Corp.
   P.O. Box C-85042
   Richmond, VA 23261-5042

7. The direct postage cost for recipient Script Limit denial letters shall be a pass-through item. The direct printing, paper, envelope, and associated costs, including but not limited to: programming, composition, and DVD archival costs shall be a pass-through item. TennCare shall reimburse First Health Services for actual costs only.
8. In the event that additional staff should be required by First Health Services to process returned mail related to recipient Script Limit denial letters, TennCare will compensate First Health Services for this additional cost at a rate of $3,622.00 per additional staff member per month. Staff shall be subject to provisions relating to approval or removal as provided in A.1. of the Contract.
9. The extract sent by First Health to the vendor will include the following fields associated with each claim:
    1. Cardholder ID
    2. Pt Last Name
    3. Pt First Name
    4. Pt Middle Initial
    5. Pt Address1
    6. Pt Address2
    7. Pt City
    8. Pt St
    9. Pt Zipcode
    10. Provider ID
    11. Provider Name
    12. Date of Service
    13. Rx Number
    14. NDC
    15. Drug Name
    p. Letter ID (template A, B, C, D)
10. First Health Services shall have the ability to recreate the letters manually. If the volume of letters requested for manual recreation increases dramatically, an automated process shall be developed.
11. The Contractor has approval to subcontract the notice process as defined herein with the requisite approval from TennCare.

Tiered Co-pay Edit
A tiered co-pay structure shall be coded into the POS system. Initially, only two tiers may be established. A more complex structure may be required by TennCare at a later date without any additional implementation or pre-operational compensation due to the Contractor.

Step Therapy
PDL management identifies and promotes the use of the most cost-effective drug therapy within a therapeutic class; step therapy promotes the use of the most cost-effective therapy for a specific indication, regardless of drug class. The POS system shall be coded to edit on all drugs in the target classes which are being submitted for dispensing. There shall need to be evidence in the claims history of prior use of a drug in a more cost-effective class before the new drug can gain approval through a prior authorization. Also included in this enhancement is the establishment of prior authorization criteria that cannot be handled with system edits but shall require calls to the Contractor's call center. The Contractor shall be responsible for making recommendations to TennCare regarding the need for such criteria and for subsequent criteria and call center protocol development. To the extent these criteria are not associated with drugs in categories reviewed for the PDL, the call center rates specified in Attachment B shall apply. The Contractor shall assure that call center staff shall be available to evaluate prior authorization requests per the standards required in section A.3.5.1 and A.3.5.3 of the contract. An agreed upon set of edits/PA criteria in this category shall be implemented during Phase II. Additional edits of this type shall be implemented at TennCare's direction at any point in the term of the Contract without additional implementation or pre-operational compensation due to the Contractor. While the Contractor shall recommend possible step therapy edits or Prior Authorization criteria for review by the Pharmacy Advisory Committee, the State shall have final decision on method and timing of implementation.

Gross Amount Due (GAD) Edit
As defined by TennCare.

Drug to Gender Edit
Any medication which is specifically indicated for either a male or female shall reject at the point of service if the medication is prescribed for a patient of the opposite gender.

Maximum Dollar Amount Edit
All pharmacy claims over a specified dollar amount per claim shall reject at the point of service and shall require the pharmacy provider to call the First Health Services Call Center. This includes a $250 limit on compounded claims, a $10,000 limit on non-compounded, non-exception claims, a $2,500 limit on Total Parenteral Nutrition (TPN) products and a $50,000 limit on exception claims (blood factors and other identified products).

DEA Number Edit
The claims processing system shall be set to deny for all controlled substances where the DEA number used is not active in the National DEA file (NTIS) used by the Contractor.

Drug Dosage and Dose Optimization Edit
The dose optimization edit shall assess the tablet strengths of a drug and assure that the most cost-effective strength is dispensed. Appropriate selection shall assist in minimizing the cost of therapy. The POS system shall be coded to limit the quantity per prescription to ensure the most cost-effective strength is dispensed. Also, where there are

appropriate concerns with respect to over-utilization of medications, quantity limits shall be entered into the system. The pharmacy shall receive a hard denial for any claim that exceeds the limit. A prescriber must obtain a prior authorization in order for the claim to process through the system.

An agreed upon set of edits in this category shall be implemented during Phase II. Additional edits of this type shall be implemented at TennCare's direction at any point in the term of the Contract without additional implementation or pre-operational compensation due to the Contractor.

Drug Duplication of Therapy Edit
This edit automatically identifies and reports problems that involve therapeutic duplications of drugs when the submitted claim is associated with other drugs or historical claims identified for a given enrollee.

OTC Drug Coverage Elimination
TennCare intends to eliminate OTC drug coverage for all adults, with the exception of prenatal vitamins for pregnant women. OTC drugs for children and prenatal vitamins for pregnant women will only be covered to the extent that they are prescribed by a health care provider legally qualified to write prescriptions.

3. Delete Section A.3.4 in its entirety and replace with the following:

A.3.4 Prior Authorization Reconsideration

A.3.4.1 Physician-Initiated Prior Authorization Reconsideration

The Contractor shall have a reconsideration process, administered by a board certified physician, in place available to providers who wish to challenge adverse prior authorization decisions. This process must ensure that appropriate decisions are made and communicated to the prescriber within twenty-four (24) hours of the initial request by a physician. The Contractor must develop policies and procedures regarding the reconsideration processes. These must be reviewed and approved by TennCare prior to implementation. The Contractor shall notify providers of the reconsideration process with respect to re-review of adverse prior authorization decisions. The Contractor will provide TennCare with monthly reports indicating the number of reconsideration requests, analysis and disposition.

A.3.4.2 Member-Initiated Prior Authorization Request

The Contractor shall establish a Member-initiated prior authorization process that allows TennCare enrollees to request a prior authorization when: twenty four (24) hours have elapsed since the claim's denial at the POS, without a prior authorization request being made by the prescriber. The Contractor shall implement and manage the Member-Initiated Prior Authorization Process as follows:

a. The Contractor shall develop a Member Call Center for incoming Member telephone calls regarding prior authorizations. The Call Center shall be fully operational and ready to receive telephone calls by January 1, 2006.

b. Upon receipt of a Member telephone call, the Contractor call service representative (hereinafter "CSR") shall confirm that twenty four (24) hours have elapsed since the provider submitted the claim and received the denial.

c. If the requisite twenty four (24) hours have elapsed, the CSR shall obtain the Member's cardholder ID number, confirm the name of the drug the Member is requesting for approval, and the name and contact information of the prescriber. The CSR shall also note if the Member has previously received this drug.

d. The CSR shall review the information in the First Traxx system to verify whether the prior authorization process has been initiated by the prescriber. If the prescriber has initiated the process, the CSR shall inform the Member of the status of the prior authorization request and ask the Member to contact the prescriber for any follow-up inquiries.

e. If the prior authorization process has not been initiated by the prescriber, the CSR shall log a prior authorization request into the First Traxx system based on the information provided by the Member. The Requester Type shall be logged as "Patient." This shall generate a facsimile to be sent to the prescriber requesting further information to determine if the Member meets the necessary criteria for the prior authorization to be granted. The prescriber has three (3) business days from the initial Member telephone call to respond to the request for further information.

f. The Contractor shall implement an operational process to identify requests that are still pending after the three (3) business day period has passed.

g. At the end of the above process, one of the four following outcomes will result:

i. The prescriber does not reply to the Contractor within the three (3) business day period. If so, the Contractor shall automatically identify requests that have not received a response, and shall initiate a letter writing process that shall inform the Member of the outcome. The Contractor shall generate and mail one of two letters to the Member. If the Member has not taken the requested drug previously, Notice Number 4 (as created and approved by TennCare) shall be sent to that Member. If the Member has taken the requested drug previously, Notice Number 5 (as created by TennCare) shall be sent to that Member. Notice Number 5 shall inform the Member of his/her Continuation of Benefits rights through the appeals process.

ii. The prescriber changes the drug initially requested to a drug on the PDL. If so, the Contractor shall log the outcome of the request into the First Traxx system. The Contractor shall contact the Member to explain this outcome and shall generate and mail Notice Number 7 (as created by TennCare) to the Member.

iii. The prescriber provides sufficient information to grant a prior authorization. If so, the Contractor shall log the outcome of the request into the First Traxx system. The Contractor shall contact the Member to explain the outcome and shall generate and mail Notice Number 8 (as created by TennCare) to the Member.

iv. The prescriber contacts the Contractor, but the prior authorization

request is denied for lack of clinical support. If so, the Contractor shall generate and mail one of two letters to the Member. If the Member has not taken the requested drug previously, Notice Number 4 (as created by TennCare) shall be sent to that Member. If the Member has taken the requested drug previously, Notice Number 5 (as created by TennCare)

shall be sent to that Member. Notice Number 5 shall inform the Member of his/her Continuation of Benefits rights through the appeals process.

h. Except for the answer and hold times of bullet point three (3) of Section A.3.5.2 of the Contract, the prior authorization call center requirements of Section A.3.5.1 through A.3.5.14 of the Contract shall apply to the Member Initiated Prior Authorization Process. Contractor shall have forty-five (45) seconds to answer Member Initiated Prior Authorization Calls and shall provide sufficient staff such that average wait time on hold per calendar month shall not be in excess of forty-five (45) seconds for Member Initiated Prior Authorization calls.

4. Delete Section A.3.6 in its entirety and replace with the following:

A.3.6 Staff Dedicated to TennCare

Pharmacy Clinical Manager
The Contractor shall provide a Pharmacy Clinical Manager to offer clinical program support to TennCare. The Clinical Manager assigned to this project must be a licensed pharmacist with a Doctor of Pharmacy degree from an accredited pharmacy school and approved by TennCare. If it becomes necessary for the Contractor to replace the Clinical Manager, the Contractor shall notify TennCare within three (3) business days of the change.

Pharmacy Contract Project Director and Staff
The Contractor shall designate and maintain, subject to TennCare approval, a Project Director for this Contract who has day-to-day authority to manage the total project. The Project Director or Reform Project Director shall be readily available to TennCare staff during regular working hours by working onsite seventy-five percent (75%) of the time within the TennCare Bureau. The Contractor's staff addressed herein shall be available to attend meetings as requested by TennCare. TennCare shall provide office space for the Contractor's onsite Pharmacy Project Director. The Contractor shall maintain sufficient levels of staff including supervisory and support staff with appropriate training, work experience, and expertise to perform all contract requirements on an ongoing basis including but not limited to the following personnel, all of whom must be dedicated 100% to TennCare:

a. one (1) clinical pharmacist located in Nashville,
b. two (2) provider educator pharmacists located in Nashville,
c. one (1) pharmacy research scientist located in Nashville,
d. one (1) data quality analyst located in Nashville,
e. one (1) system liaison located in Richmond and available in Nashville upon request from TennCare,
f. one (1) contract manager located in Richmond,
g. one (1) business analyst located in Richmond,
h. one (1) reform project director to address program changes based 25% in Nashville and 75% in Richmond.
i. two (2) mail room clerks located in Richmond.

Telephone and administrative personnel shall be familiar with covered services under the TennCare pharmacy program and other member eligibility prerequisites. TennCare shall have the right to approve the Project Director and any other key positions. TennCare shall have the right to require removal, in writing, from this Contract of any staff found unacceptable to TennCare with cause. TennCare shall be notified within three (3) business days of key staffing changes and name changes and TennCare shall have the right to approve any such changes. The Project Director shall provide overall project coordination between the clinical and operational aspects in support to TennCare. If it becomes necessary for the Contractor to replace the

Project Director, the Contractor shall notify TennCare within three (3) business days of the change and TennCare shall approve any such changes.

5. Delete Section A.9 by in its entirety and replace with the following:

A.9. TennCare Pharmacy Staff and TennCare MCO Pharmacy and Utilization Staff Online Access to Contractor Program Systems

The Contractor shall provide the TennCare Pharmacy Unit and other appropriate TennCare staff individual access, at no additional cost to TennCare, except as expressly detailed in Section C of the Contract, to the Contractor's POS claims history system, prior authorization system, eligibility files and other information as necessary via an online, real time connection. The TennCare managed care organizations (MCOs) must have access to their enrollees' pharmacy claims data in an online, real time manner to effectively perform case management and utilization management processes. The Contractor will provide secure access to the systems and data described above for each TennCare MCO's appropriate staff.

The Contractor shall provide for the appropriate TennCare staff to have external access to the First Traxx system for purposes of viewing TennCare data contained therein.

6. Delete Section A.14 in its entirety and replace with the following:

A.14 The Emergency Supply Override

The Contractor shall assure that the TennCare-POS systems allows pharmacists to execute an emergency override that shall process an emergency seventy-two (72) hour supply of drugs in normally covered therapeutic categories that are not listed on the TennCare PDL. The Contractor's TennCare-POS system must post a message for the dispensing pharmacist to contact the prescriber, so that the pharmacist can suggest alternative therapies listed on the TennCare PDL. Drugs eligible for the emergency override must be in a therapeutic class normally covered by TennCare. The Contractor shall instruct pharmacy providers how to perform the emergency override in the National Council of Prescription Drug Programs (NCPDP) environment of the TennCare-POS pharmacy claims processing system.

The Contractor shall make the following coding modifications to the TennCare-POS pharmacy claims processing system:

a. The Contractor shall reserve "Grier Code" number "8" for use only for emergency overrides. The use of this code shall be limited to one instance per TennCare enrollee per prescription.

b. The Contractor shall eliminate "Grier Codes" numbers "1" and "7," which are no longer needed with the implementation of TennCare's "72 Hour Emergency Supply Policy."

The Contractor shall work with TennCare to develop guidelines for pharmacists to use in assessing whether or not a true "emergency" exists. The Contractor shall train pharmacists on the use of those guidelines prior to implementing any changes to the override procedure.

If further modification of the emergency override system is necessary to comply with any changes in the consent decree or to control pharmacy costs in a manner consistent with the current consent decree, the Contractor shall make such modifications as directed by TennCare.

A requirements session will be conducted to identify the required logic, a business plan shall be developed, and the changes shall be implemented after sufficient time has been allotted for coding and testing of all changes. Such coding changes shall be compensated at the System Change Request hourly rate.

Failure by the Contractor to allow the POS emergency override for all appropriate, emergency claims may result in the assessment of liquidated damages by TennCare of two hundred dollars ($200) per day during the first moth violations are identified. Liquidated damages will increase to four hundred dollars ($400) per day for the second consecutive month violations are identified. TennCare will monitor emergency overrides and notify the Contractor of any violations as well as any possible sanctions related to those violations. The Contractor will have seventy-two (72) hours, following written notification, to correct all violations prior to assessment of liquidated damages by TennCare. The Contractor shall submit to TennCare, within twenty-four (24) hours, a written corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

7. Add the following language to Section C.3.1:

C.3.1. Pricing and Payment for Technical Changes Pursuant to *Grier* Required Changes

The State shall pay the Contractor the following fees for the technical work and services to be performed pursuant to the changes required under the August 3 and August 9, 2005 Orders under the *Grier Revised Consent Decree (Modified)*:

a. First Traxx enhancements: a one-time implementation fee of eighty-three thousand, seven hundred dollars ($83,700.00) will be due and payable upon execution of this contract.

b. First Traxx server maintenance support and storage: a monthly administrative fee of twelve thousand, five hundred dollars ($12,500.00) will be billed monthly beginning January 1, 2006.

c. First Traxx external deployment: a one-time implementation fee of twenty thousand dollars ($20,000.00) will be due and payable upon execution of this contract.

d. First Traxx training and support: a one-time implementation fee of twenty-five thousand, five hundred dollars ($25,500.00) will be due and payable upon execution of this contract.

e. First Traxx user fee: the State shall pay the Contractor a per user seat fee of two thousand, five hundred dollars ($2,500) per year per user. The Contractor shall invoice the State the annual fee for each user the month following the addition of the user and annually thereafter during the same calendar month the user was first added, for so long as the user is active.

f. IVR enhancements: a one-time implementation fee of one hundred and ten thousand, seven hundred dollars ($110,700.00) will be due and payable upon execution of this contract.

g. IVR server maintenance support and storage: a monthly administrative fee of twelve thousand, five hundred dollars ($12,500.00) will be invoiced to the State monthly beginning January 1, 2006.

h. First Traxx/IVR Technical support: a one half full-time equivalent (FTE) monthly administrative fee of three thousand, seven hundred and fifty dollars ($3,750.00) will be invoiced to the State monthly beginning January 1, 2006.

i. Senior business analyst, based in Nashville: upon hiring a monthly fee of nine thousand, two hundred and sixteen dollars ($9,216.00) will be invoiced to the State monthly.

j. Plan administration/quality control testing: a one-time implementation fee of twenty-seven thousand dollars ($27,000.00) will be due and payable upon execution of this contract.

k. Crystal template interface development: a one-time implementation fee of eighteen thousand dollars ($18,000.00) will be due and payable upon execution of this contract.

l. Interface development change fee: a fee of two hundred and twenty-five dollars ($225.00) per letter update will be invoiced upon Contractor's receipt of the State's written request for modification of notification letter(s).

m. Call Center Member-initiated prior authorization implementation: a one-time implementation fee of thirty-three thousand, five hundred dollars ($33,500.00) will be due and payable upon execution of this contract.

n. Call Center Member-initiated clinical prior authorizations: a per call rate of seven dollars and twenty-two cents ($7.22) per pharmacy technician call and a fifteen dollars and fifteen cents ($15.15) per pharmacist call will be billed to the State by the Contractor. The Contractor will invoice the State monthly in arrears for Member-initiated prior authorization telephone calls.

o. Notice generation: the Contractor may use a subcontractor or vender to generate the Notices to Members. All costs associated with notice generation, including but not limited to: data extraction, programming, formatting, printing, mailing, postage, labor and associated costs shall be a direct pass through expense to the State. Notice generation work that must necessarily be performed by the Contractor to assist the selected subcontractor or vendor shall be billed at the applicable rates set forth in the Contract. In the event the Contractor decides not to or is unable to use a subcontractor or vendor to perform the notice generation work, the parties shall enter into good faith negotiation to agree upon the fees and expenses to be charged by the Contractor for the notice generation work. Any such agreement reached by the parties shall be reduced to writing and signed by authorized representatives of the parties, and may be incorporated into any possible future amendment to this Contract.

p. Pre-operational Call Center fee: the State shall pay the Contractor a weekly fee of eight thousand, two hundred and eighty dollars ($8,280.00) for each full week, or part thereof, subsequent to execution of this contract during which the Contractor's call center is not receiving Member-initiated prior authorization telephone calls unless any such delay is due solely to the Contractor's failure to perform. This provision shall not be deemed to be punitive in nature and is specifically intended to properly compensate the Contractor for the expenses of operating a call center during any periods of delayed implementation of the Member-Initiated Prior Authorization Process.

All periodic (weekly, monthly, or annual) and per telephone call fees set forth above shall remain fixed through the current Contract term, which expires on December 31, 2006.

The State shall have two (2) additional one year options that it may exercise to extend the Member-Initiated Prior Authorization Process for up to two (2) additional years past the current expiration date. During any such extension(s), periodic and per telephone call fees shall be increased at the rate of four percent (4%) per year. If the State desires to extend the Member-Initiated Prior Authorization Process, it shall provide the Contractor with no less than one hundred and twenty (120) days prior written notice before December 31, 2006.

8. Delete Section E.9. in its entirety and replace with the following:

E.9. Lobbying.

A. Definitions

(1) Lobbying means to communicate, directly or indirectly, with any official in the legislative or executive branch, for pay or for any consideration, for the purpose of influencing any legislative action or administrative action. (T.C.A. § 3-6-102(13))

(2) Public Official means any elected official, appointed official, or employee of:

(a) A federal, State or local unit of government in the United States.

(b) A government corporation. (2 U.S.C.A. § 1602(15)(A) and (B))

(3) Official in the Executive Branch means the governor, any member or the governor's staff, any member or employee of a state regulatory commission, including, without limitation, directors of the Tennessee regulatory authority, or any member or employee of any executive department or agency or other state body in the executive branch. (T.C.A. § 3-6-102(16))

(4) Official in the Legislative Branch means any member, member-elect, any staff person or employee of the General Assembly or any member of a commission established by and responsible to the General Assembly or either house thereof who takes legislative action. This includes the Secretary or State, Treasurer, and Comptroller of the Treasury and any employee of such offices. (T.C.A. § 3-6-102(17))

B. The Contractor certifies by signing this Contract, to the best of its knowledge and belief, that Federal funds have not been used for lobbying in accordance with 45 CFR 93.100 and 31 U.S.C. 1352. Regardless of funding source, lobbyist compensation cannot be directly or indirectly contingent on 1) the passage or defeat of a bill related to TennCare or sister health departments, 2) the number of covered TennCare enrollees, or 3) the amount of TennCare reimbursement to a vendor. Certification from the Contractor must include the following:

(1) No appropriated funds may be expended by the recipient of this Contract to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress, an elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS) or any other federal agency in connection with this Agreement or subcontractors, vendors, agents, providers, representatives and others with verbal or written agreements with the Contractor which receive reimbursement through this Agreement from the Contractor.

(2) The Contractor must certify annually by filing a TennCare Disclosure of Lobbying Activities Form (Attachment D) with TennCare and the TennCare Oversight Committee that the Contractor is in compliance with all state and federal laws relating to conflicts of interest and lobbying. This form must be signed by the Chief Executive Officer of the Contractor or his/her designee and must be received by TennCare and the TennCare Oversight Committee no later than December 31, of each year. The certification must include any and all subcontractors, vendors, agents, providers, representatives and others with verbal or written agreements with the Contractor which receive reimbursement through this Agreement from the Contractor. The certification must also include signed copies of any contracts or agreements as well as a list of individual entities who have been lobbied or influenced.

Failure by the Contractor to comply with the provisions herein shall result in termination of the Contract as provided in Section D.4.

9. Add the following language as Sections E.22 and E.23:

E.22. Conflicts of Interest

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The Contractor warrants that during the term of this Agreement no payments shall be paid to the following:

(1) any State or federal officer, including but not limited to

a. a member of the State Legislature, or
b. a member of Congress, or
c. any immediate family member of any State or federal officer; or

(2) any State or federal employee or any immediate family member of a State or federal employee unless otherwise authorized in writing by the Commissioner, Tennessee Department of Finance and Administration. Immediate family members may be exempted if State or federal officer or employee discloses such relationship to TennCare and the TennCare Oversight Committee. The applicability of this section includes, but is not limited to, any and all arrangements and/or agreements, written or verbal, that result in the Contractor making a payment or providing a gift in exchange for services or supplies.

The Contractor must certify annually by filing a TennCare Disclosure of Lobbying Activities Form (Attachment D) with TennCare and the TennCare Oversight Committee that the Contractor is in compliance with all state and federal laws relating to conflicts of interest and lobbying, having made diligent inquiry of all subcontractors and/or persons receiving payment or gifts from Contractor pursuant to this Agreement. This form must be signed by the Chief Executive Officer of the Contractor or his/her designee and must be received by TennCare and the TennCare Oversight Committee no later than December 31 of each calendar year. The certification must include any and all subcontractors, vendors, agents, providers, representatives and others with verbal or written agreements with the Contractor which receive reimbursement through this Agreement from the Contractor. The Chief Executive Officer acknowledges that he/she is responsible for ensuring that internal controls are in place to prevent and detect potential conflicts of interest and that due diligence was performed before providing certification of compliance. Any changes by the Contractor relating to the disclosure of conflicts of interest or lobbying must be disclosed to TennCare within five (5) business days of the date of the change. (Refer to E.9, lobbying activities).

This Agreement may be terminated by TennCare if it is determined that the Contractor, its agents or employees offered or gave gratuities of any kind to any official, employee or immediate family member of an employee of the State of Tennessee, including a member of the State legislature. This Agreement may be terminated by TennCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, his agent, or employees.

Failure to comply with the provisions required herein shall result in liquidated damages in the amount of one-hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of this Agreement as described in Section E.4 and Attachment A, Liquidated damages, and subject to termination of this Agreement.

The Contractor shall be responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and include the substance of this clause in all agreements, subcontracts, provider agreements, and any and all agreements that result from this Agreement between Contractor and TennCare.

E.23. Offer of Gratuities. By signing this Contract, the Contractor signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially from this procurement. This Contract may be terminated by TennCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, his agent, or employees and may result in termination of the Contract as provided in Section D.4.

10. Amend Attachment A, Liquidated Damages for Performance Measures, of Amendment Two to FA 04-15757-00 by replacing page 1 of said Attachment A with the Revised page 1 of Attachment A, which is attached hereto and incorporated by reference herein.

11. Add Attachment D, Disclosure of Lobbying Activities Form and Instructions.

IN WITNESS WHEREOF:

FIRST HEALTH SERVICES CORPORATION:

Teresa R. DiMarco, President **Date**

DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE:

M. D. Goetz, Jr., Commissioner **Date**

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr., Commissioner **Date**

COMPTROLLER OF THE TREASURY:

John G. Morgan, Comptroller of the Treasury **Date**

ATTACHMENT A

LIQUIDATED DAMAGES FOR PERFORMANCE MEASURES

PERFORMANCE MEASURE	REPORTING REQUIREMENT	DELIVERABLE	PENALTY
A.1.1 Program Enhancements	Within thirty (30) days of signature of this Amendment, the Contractor shall develop a report format for TennCare review and approval. Said report shall be designed to provide TennCare with monthly updates regarding the cost savings attributed to each program enhancement included in this Amendment. Following TennCare approval of the report format, said report shall be generated monthly and posted in First Decision.	Within thirty (30) days of signature of Amendment, report format is due for TennCare review. Reports due monthly, on the last business day of the month following the end of the monthly reporting period, beginning for the first full month after the report format has been agreed to FirstIQ reports are due monthly, fifteen (15) days after the end of the monthly reporting period.	Damages will be assessed weekly. Calculation of the damages will begin on the first day following the report due date and will continue until receipt of the report by TennCare. Penalty will be $2,500 per week.

ATTACHMENT D

INSTRUCTIONS FOR COMPLETION OF LOBBYING DISCLOSURE FORM FOR THE BUREAU OF TENNCARE

This disclosure form shall be filed with TennCare and the TennCare Oversight Committee annually by the reporting entity no later than December 31 of each year; however an ongoing duty exists to amend and update all filings. All TennCare-related lobbying relationships and/or contracts should be disclosed on a separate form. Disclosure is required if any portion of funds received under a contract, grant or other relationship with TennCare was paid to a lobbyist or lobbying entity as defined by Tenn. Code Ann. 3-6-102 and as further defined in E.9 of the Contract. For those Contractors reliant on TennCare for greater than two-thirds of their total revenue in the previous fiscal year, all lobbying contracts will be presumed to be TennCare-related. This form has been designed consistent with federal regulations, 31 U.S.C. 1352 and 42 CFR 93.100. Refer to the implementing guidance provided by the Federal Office of Management and Budget for additional information.

1. Identify the type of lobbying relationship being disclosed (*e.g. ongoing, one-time).* Use a separate form for each lobbyist contract or relationship.

2. Identify the purpose of the lobbying relationship as quoted in the contractual agreement.

3. Identify the appropriate classification of this disclosure. Any material change to information previously reported should be disclosed in an amended form within five (5) business days.

4. Enter the full name, address, city, state and zip code of the reporting entity.

5. Enter the total reimbursement paid to lobbyist in the previous fiscal year.

6. Enter the full name, job title, address, city, state and zip code of the lobbying registrant engaged by the reporting entity identified in item 4.

7. Enter the full name(s) of the individual(s) performing services and include full address if different from item 6. Enter last name, first name, middle initial (MI), and job title.

8. Enter the full name(s), job title(s) of individuals lobbied, the subject matter of the lobbying activity(ies) and the total value of all gifts/remuneration received. (See Tenn.Code Ann. 3-6-102 and Section E.9 of the Agreement for a definition of relevant lobbying activities)

9. The certifying contractor or vendor Chief Executive Officer shall sign and date the affirmation, print his/her name, title, and telephone number.

LOBBYING DISCLOSURE

Complete this form to disclose TennCare-related* lobbying relationships entered into or existing in the previous fiscal year. Each lobbying relationship/contract requires a separate form.

State of Tennessee
Bureau of TennCare

1. Type of Relationship: *(e.g., ongoing, one-time)*	**2. Stated Purpose of the Relationship:**	**3. Report Type:** a. Initial Filing b. Material Change **For Material Change Only:** Year _____ Quarter _____ Date of last Report _____

4. Name and Address of Reporting Entity:	**5. Total Reimbursement Paid to Lobbyist:** $
6. Name and Address of Lobbying Registrant: (*If individual, last name, first name, MI)*	**7. Individuals Performing Services:** (*Including address if different from No. 6)*

8. List of Individuals Lobbied:
(Including name, job title, subject matter of lobbying activity(ies) and total value of all gifts/remuneration received)

9. "I hereby affirm that to the best of my knowledge my organization and its sub-contractors remain in compliance with state contractual requirements barring payment to state officials."

Signature: _____

Print Name: _____ Title: _____

Telephone No.: _____ Date: _____

* Disclosure is required if any portion of a lobbying relationship relates to TennCare. For those Contractors reliant on TennCare for greater than two-thirds of their total revenue in the previous fiscal year, all lobbying contracts will be presumed to be TennCare-related.

** Attach additional sheets if necessary. Include the name of the Reporting Entity and date on each additional sheet.

CONTRACT SUMMARY SHEET

RFS Number:	318.65-128	**Contract Number:**	FA-04-15757-02
State Agency:	Department of Finance and Administration	**Division:**	Bureau of TennCare

Contractor	**Contractor Identification Number**	
First Health Services Corporation	X V- C-	540849793 03

Service Description

Point of Sale (POS) Pharmacy Claims Processing and Preferred Drug List Development and Management

Contract Begin Date	**Contract End Date**
January 1, 2004	December 31, 2006

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.65	073	134	11	X on STARS		

FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)
2004	$1,453,500.00	$1,453,500.00			$2,907,000.00
2005	$4,757,822.00	$4,757,822.00			$9,515,644.00
2006	$8,487,366.00	$8,487,366.00			$16,974,732.00
2007	$4,251,312.00	$4,251,312.00			$8,502,624.00
Total:	**$18,950,000.00**	**$18,950,000.00**			**$37,900,000.00**

OCR RELEASED
MAY 17 2005
TO ACCOUNTS

CFDA #	93.778 Department of Health & Human Services Title XIX	**Check the box ONLY if the answer is YES:**	
State Fiscal Contact		**Is the Contractor a SUBRECIPIENT?** (per OMB A-133)	x
Name:	Scott Pierce	**Is the Contractor a VENDOR?** (per OMB A-133)	
Address:	729 Church Street	**Is the Fiscal Year Funding STRICTLY LIMITED?**	
Phone:	Nashville, TN (615) 532-1362	**Is the Contractor on STARS?**	x
Procuring Agency Budget Officer Approval Signature		**Is the Contractor's FORM W-9 ATTACHED?**	
		Is the Contractors Form W-9 Filed with Accounts?	x

MAY 20 2005

COMPLETE FOR ALL AMENDMENTS (only)		
	Base Contract & Prior Amendments	**This Amendment ONLY**
END DATE →	12/31/2006	
FY: 2004	$2,907,000.00	
FY: 2005	$5,387,100.00	$4,128,544.00
FY: 2006	$4,589,100.00	$12,385,632.00
FY: 2007	$2,309,800.00	$6,192,824.00
FY:		
Total:	**$15,193,000.00**	**$22,707,000.00**

Funding Certification

Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

MAY 20 2005
DIRECTOR OF ACCOUNTS

FA 04-15757-02

IN WITNESS WHEREOF:

FIRST HEALTH SERVICES CORPORATION:

Teresa R. DiMarco, President
Date 3/16/05

DEPARTMENT OF FINANCE AND ADMINISTRATION, TENNCARE BUREAU

M. D. Goetz, Jr., Commissioner
Date 4/29/05

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

MAY 3 2005

M. D. Goetz, Jr., Commissioner
Date

COMPTROLLER OF THE TREASURY:

John G. Morgan, Comptroller of the Treasury
Date 5-16-05

AMENDMENT TWO TO FA 04-15757-00, THE CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
BUREAU OF TENNCARE
AND
FIRST HEALTH SERVICES CORPORATION

This Amendment, by and between the State of Tennessee, Department of Finance and Administration, TennCare Bureau hereinafter referred to as the "State" or "TennCare" and First Health Services Corporation, hereinafter referred to as the "Contractor," is for the provision of Pharmacy Management and Preferred Drug List Services, as further defined in the "SCOPE OF SERVICES" is amended as follows:

1. Amend Section A.1. by deleting the entire section and substituting with the following:

A.1.1 **Program Enhancements**

Effective upon signature of this Amendment, the Contractor shall begin implementation of Program Enhancements and/or changes as directed by TennCare and as provided herein. Implementation shall be in three phases, Phase I, Phase II and Phase III. The start date for each phase is either (1) a date certain as shown on the chart below or (2) a number of days (as specified herein) after written notification by TennCare to the Contractor. The Program Enhancements in each Phase are set out below, including implementation deadlines. Many of these enhancements will result in telephone calls to the First Health Call Center. The Contractor agrees to staff the call center which is required under the Contract and operate it in accordance with the standards as required by Sections A.3.5.1 to A.3.5.3. Upon signature of this Amendment and as these enhancements become operational, TennCare agrees to compensate the Contractor for calls as outlined in Attachment B. The Contractor acknowledges that calls related to the preferred drug list ("PDL") are covered under the base contract and will not be reimbursed at the rates noted in Attachment B. The Contractor will assure that TennCare is not billed for such PDL-related calls and will submit monthly reports to TennCare detailing the numbers of resolutions associated with the PDL as well as the number of non-PDL related resolutions by edit and by type (technician, pharmacist or physician). Further the Contractor may not bill TennCare for any calls that are the result of an error or omission on their part in administration of the pharmacy benefit, including errors or omissions in the implementation of an edit.

Within thirty (30) days of signature of this Amendment, the Contractor and TennCare shall conduct a requirements session to develop a report format for TennCare review and approval. Said report shall be designed to provide TennCare with monthly updates regarding the cost savings attributed to each Program Enhancement included in this Amendment. Following TennCare approval of the report format, said report shall be generated monthly and posted in First Decision.

Additional payment as agreed to by the Parties and as provided in this Amendment is the complete and whole compensation for implementation of the types of edits and services listed in the chart below. TennCare shall not pay additional implementation or pre-operational compensation in the event that additional, related edits are needed and which are reasonable, actual and necessary for the TennCare program,

Failure to meet deadlines as required herein, failure to provide reports or failure to implement Program Enhancements as required herein may result in liquidated damages and/or Breach by Contractor and are subject to remedies as provided in Section E.4. of the Contract. Prior to assessment of the damages provided in Section E.4, the parties

agree to discuss the pertinent issues and make a determination as to the reason or responsibility for the failure to meet the deadlines as required or failure to implement Program Enhancements as required. If there is a failure by TennCare which directly contributes to the failure by the Contractor to meet deadlines or provide reports, TennCare agrees that that will be a major consideration in assessing responsibility.

Phase I Implementation

PROJECT	SUB-PROJECT	DATE PROJECT TO BEGIN	DATE TO COMPLETE IMPLEMENTATION
Script Limit Edits (see Contract Section A.2.2.3(i))	N/A	Upon signature of this Contract Amendment Two	No later than May 1, 2005
Tiered Co-Pay Edits (see Contract Section A.2.2.4(c))	N/A	Upon signature of this Contract Amendment Two	No later than May 1, 2005
Over-the-Counter Drug Coverage Elimination	N/A	Upon signature of this Contract Amendment Two	No later than May 1, 2005
Step Therapy		Upon signature of this Contract Amendment Two	No later than May 1, 2005
Administrative Edits	Gross Amount Due Edit	Already Implemented	Already Implemented
	Drug to Gender Edit	Already Implemented	Already Implemented
	Maximum Dollar Amount Edit	Already Implemented	Already Implemented
	DEA Number Edits	Already Implemented	Already Implemented
Clinical Edits	Drug Duplication of Therapy Edit (see Contract Section A.2.2.9(a)(ii))	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	Drug Dosage & Dose Optimization Edit	Upon signature of this Contract Amendment Two	No later than May 1, 2005
Additional Dedicated Staff	(1) Clinical Pharmacist based in Nashville	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(2) Provider Educator Pharmacists based in Nashville	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(1) Pharmacy Research Scientist based in Nashville	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(1) Data Quality	Upon signature of	No later than May 1, 2005

	Analyst based in Nashville	this Contract Amendment Two	
	(1) Systems Liaison based in Richmond	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(1) Contract Manager based in Richmond	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(1) Business Analyst based in Richmond	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(1) "Reform" Project Manager based 25% in Nashville, balance in Richmond	Upon signature of this Contract Amendment Two	No later than May 1, 2005
	(2) Mail Room Clerks	Upon signature if this Contract Amendment Two	No later than May 1, 2005
Retro Dur	N/A	Upon signature of this Contract Amendment Two	No later than May 1, 2005

Phase II Implementation

PROJECT	SUB-PROJECT	DATE PROJECT TO BEGIN	DATE TO COMPLETE IMPLEMENTATION
Administrative Edits	Unit of Measure Edit	Upon written notification from TennCare	The latter of July 1, 2005 or sixty (60) days following written notification from TennCare
	MAC/DAW Edit	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare
MAC	N/A	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare

Phase III Implementation

PROJECT	SUB-PROJECT	DATE PROJECT TO BEGIN	DATE TO COMPLETE IMPLEMENTATION
Administrative Edits	Prescriber Last Name Edit	Upon written notification from TennCare	The latter of July 1, 2005 or sixty (60) days following written notification from TennCare
Clinical Edits	Drug Duration Edit	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare

	Drug-to-Disease Edit (see Contract Section A.2.2.9(a)(iii))	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare
	Drug-Drug Interaction Edit (see Contract Sections A.2.2.9(a)(iv) and A.2.2.9(a)(v))	Upon written notification from TennCare	Sixty (60) days following written notification from TennCare

2. Amend Section A.2.1 by deleting the entire section and substituting with the following:

A.2.1 Retro-DUR Enhancements – Phase I Implementation

a. In addition to the responsibilities already required of the Contractor for the Retro-DUR program, the Contractor shall also assume an expanded role and shall implement a complete Retro-DUR program to be coordinated and maintained by a full-time Clinical Pharmacist dedicated to TennCare and supported by provider educators who are licensed pharmacists as well as eight (8) profile reviewers who are also licensed pharmacists. In addition, the Contractor's dedicated Clinical Pharmacist shall be responsible for the operation of the DUR Board including the recruitment of DUR Board members, with consultation from TennCare.

b. Description of the Operation of the Retro-DUR Program
The Contractor shall provide to TennCare all necessary components of a Retro-DUR program and shall operationalize those as follows:

i. Establish a Drug Utilization Review (DUR) Board, which shall require the following:

A. The Contractor's Clinical Pharmacist shall recruit and maintain a DUR Board composed of five (5) physicians, five (5) pharmacists, one (1) nurse practitioner alternating with one (1) physician assistant as suggested by the Contractor.

B. Selection of DUR Board members shall be based on medical and pharmacy expertise and willingness to serve in this capacity and provide the services specified by TennCare in writing. Members shall be required to be available for quarterly meetings and to review drug information and drug utilization materials as necessary to improve patient quality of care, to prevent fraud and abuse, and to control the costs of drug utilization.

C. The process of selecting DUR Board members shall incorporate suggestions concerning pharmacy providers from the Tennessee Pharmacist Association (TPA) and concerning physicians from the Tennessee Medical Association (TMA).

D. The Clinical Pharmacist shall consult with TennCare to obtain the approval by TennCare of the DUR Board make-up.

E. The primary role of the DUR Board is to provide program oversight and direction.

F. The Contractor shall send all DUR Board members a letter explaining that the responsibility for the Retro-DUR program is being transitioned to the Contractor and for new members a Letter of Appointment that shall specify lengths of terms, to be staggered.

G. The Contractor shall determine quarterly dates for the DUR Board meetings and determine the agenda for those meetings. Minutes for those meetings are to be taken by First Health Staff and shall be disseminated as appropriate. The Clinical Pharmacist shall prepare the following reports/information for presentation at DUR Board meetings:

1. TennCare utilizing-members data;
2. TennCare utilization by age demographics;
3. TennCare utilization by top ten (10) therapeutic classes determined both by number of claims and by payment amount;
4. TennCare top ten (10) drugs as ranked by claim count and by total payment;
5. Pro-DUR data including totals of Pro-DUR messages sent and savings associated with the top ten (10) drugs associated with each Pro-DUR edit;
6. Retro-DUR intervention analysis and cost savings information as associated with both member profile review and interventions and provider profile interventions;
7. Distribution of Clinical Alerts as prepared monthly by the Contractor's Clinical Management staff;
8. Additional reports can be presented at the DUR Board meetings, as requested by TennCare.

ii. Recruit, maintain, and reimburse a panel of eight (8) clinical pharmacists to review member profiles. These clinical pharmacists shall each review one hundred (100) member profiles monthly so that a total of eight hundred (800) member profiles will be reviewed monthly, or a minimum of two thousand, four hundred (2,400) member profiles per quarter. The clinical pharmacists shall recommend appropriate interventions related to each profile reviewed.

iii. Provide TennCare read only access to First IQ™, a reporting tool to provide data analysis, profile production, letter interventions and tracking of all interventions, both letters and direct communication, to determine cost savings as related to the specific interventions accomplished. First IQ™ is also used to record intervention responses from providers. A number of reports, including Criteria Exception Estimates, Retro-DUR Profile Exceptions, Retro-DUR Intervention Analysis and Monthly Cost Savings, are reviewed and presented to the DUR Board and TennCare as determined appropriate by First Health.

iv. Maintain and update a set of clinical criteria in First IQ™ to be used in the profile production and exception processing program. Clinical criteria shall meet all CMS requirements and be developed and maintained to detect instances such as polypharmacy and related overutilization, underutilization, drug to drug interactions, therapeutic duplications, incorrect drug dosage and duration of treatment, possible fraud and abuse issues, and other instances of inappropriate drug therapy as may also be related to a member's age or disease state.

v. Determine the focus for each of the four (4) quarterly provider profile runs and for each of the twelve (12) monthly member profile runs as determined by analysis of drug utilization in the TennCare Program. Additional topics as requested by TennCare can be reviewed as mutually agreed upon. The criteria used in the review process can be selected from the standard criteria or "forced", to review specific issues, as determined appropriate by the Clinical Pharmacist.

vi. Produce member profiles on a monthly basis, eight hundred (800) profiles per month or a minimum of two thousand, four hundred (2,400) member profiles per quarter, and distribute to clinical reviewers for review and determination of appropriate interventions to be taken. Typically, mailings are sent to prescribers or pharmacy providers but phone calls or visits can also be conducted as determined appropriate and/or upon the direction of TennCare. Mailings include an intervention letter to the prescriber or pharmacy provider detailing the reason for the intervention, a member profile to include details of previous interventions, medication history, medical claims data and any Pro-DUR messages sent to the pharmacy during claim adjudication. A response form is also sent in the mailing. The postage associated with these mailings will be reimbursed by TennCare as a pass-through cost.

vii. Produce provider profiles on a quarterly basis, two thousand, four hundred (2,400) profiles per quarter and determine appropriate interventions which are typically mailings to include a letter with recipient detail included and educational materials as appropriate. Telephone calls and/or provider visits might also be determined appropriate.

Unlike member profiling, provider profiles are not reviewed by clinical reviewers, as they simply detail members for whom a prescriber or pharmacy provider has prescribed or dispensed medication that meet criteria exceptions reviewed for the quarter.

The criteria used in the review process can be selected from the standard criteria or "forced" as determined appropriate by the Clinical Pharmacist. This program can also be used for Behavioral Health Organization prescriber notifications or in conjunction with any interventions requested by the Office of Inspector General.

Once criteria is selected and provider exceptions determined, interventions are to be in the form of mailings to include a letter descriptive of the issue reviewed, a provider profile of members who have excepted on the selected criteria, a provider response form, educational materials as appropriate, and a Provider "Report Card/Profiling Analysis." Direct interventions in the form of phone calls or visits can also be accomplished as appropriate.

Provider Profiling Reports that offer important information related to the quarterly reviews include, but are not limited to, a Provider Exception Report, Response Summary Report, and a Provider Profiling Audit Report.

viii. Report quarterly to the DUR Board on monthly member reviews and quarterly provider reviews to include interventions taken and responses and outcomes.

ix. Produce an Annual Drug Utilization Review Report for the TennCare program according to the annual CMS requirements.

x. The Board may request reports as needed to conduct business as provided herein.

c. Cost Savings Associated with Retro-DUR

Retro-DUR is focused on provider education through intervention to reduce inappropriate drug utilization and to improve clinical outcomes. Additionally, a well managed program shall generate cost savings through the alteration and improvement in prescribing and dispensing practices as well as the reduction in instances of fraud and abuse.

First IQ™ Retro-DUR cost savings are based on interventions (letter, telephone call, or face-to-face) with a provider (prescriber and/or pharmacy provider) related to a patient identified through a Retro-DUR profile review cycle. The intervention moves the case to the cost savings tracking system. The Therapeutic Class(es) related to the criteria involved in the exception, is captured and tracked. The average cost per day of the Therapeutic Class for the intervened patient is calculated based on a three-month intervention period. This cost is used as a comparative baseline figure in the monthly cost savings calculation. There is then a six (6) month waiting period before cost savings begin to be calculated, which allows time for the intervened provider to make the appropriate changes in therapy. Once the waiting period has elapsed, the average cost per day for the original therapeutic class is calculated based on the current utilization. This cost is then compared with the "baseline" cost and the difference is the cost savings (or cost increase, as the case may be in some quality of care interventions). This comparative calculation is systematically performed each month and the case is tracked for twelve (12) months. Each month a cumulative Retro-DUR cost savings is reported based on the active cases in the tracking system. This cost savings methodology provides TennCare with reasonable cost savings data as it relates to the Retro-DUR program.

3. Amend Section A.2.2.1 by deleting the entire section and substituting with the following:

A.2.2.1. Claim Adjudication Services - General Requirements.

This section defines claim adjudication requirements for all TennCare pharmacy claims regardless of source and including electronic batch, paper and POS claims. The timing of the adjudication shall differentiate POS claims from claims submitted in batch or on paper, however, all claims must be adjudicated through a common set of processing modules. All claims adjudicated as payable must be for eligible members to enrolled or appropriate providers for approved services and in accordance with the payment rules and other policies of TennCare. All adjudicated and paid claims shall be transferred

weekly to the TennCare TCMIS by the Contractor. The Contractor shall distribute and mail TennCare outputs (hard copy and electronic) as directed by the TennCare Bureau including but not limited to provider checks and remittance advices, returned claims, notices, provider bulletins, provider manuals and special mailings. The Contractor shall mail checks and remittance advices to pharmacy providers each week on Fridays, with the exception of holiday weeks, for all claims submitted through the POS online pharmacy claims processing system up through the preceding Monday.

The contractor shall use first class rate for all client mailings. Mailing costs incurred by the Contractor shall be treated as pass-through costs. Such costs shall be billed on a monthly basis to the TennCare Bureau in addition to regular invoices and must include substantiating documentation. No overhead, administrative or other fee shall be added to such pass-through costs. Each batch must have its own reconciliation and money remits. The Contractor shall be responsible for system messages and notice of claims being adjudicated payable, denied or suspended.

a. Cash flow – For checks to be issued on Friday, the Contractor must deliver the following two files to the State, in an electronic media suitable to the State, by 10:00 a.m. Thursday of each week:

   i. all transactions (claims, financial adjustment, etc.) that comprise the payments to be issued for Friday of that week;

   ii. all payments (check register) to be made on Friday of that week TennCare shall be notified no later than five (5) business days of any systems or operational issues that may impact disbursements by the prescribed time lines.

   The file described in i. above, must contain all transactions that make up the payments in the file described in number ii. above.

b. The State reserves the right to review the files prior to issuing payment and to hold or adjust any payment that is not satisfactory to the State. The State also reserves the right to withhold amounts owed to the State by any provider for which the Contractor submits a payment request. The Contractor is encouraged to offer automatic deposit to its providers. The Contractor is responsible for providing remittance advices to providers unless the provider elects not to receive hardcopy RA's. Remittance advices shall be included in payments by the Contractor to providers. The Contractor is responsible for ensuring that any payments requested are accurate and in compliance with the terms of this contract, agreements between the State or Contractor and providers, and state and federal laws and regulations.

c. The Contractor shall have in place, a POS claims processing system capable of accepting and processing claims submitted electronically. To the extent that the Contractor compensates providers on a fee for service or other basis requiring the submission of claims as a condition to payment, the Contractor shall electronically process, as described herein, the provider's claims for covered benefits provided to members consistent with applicable TennCare policies and procedures and the terms of this Agreement. The Contractor shall mail checks and remittance advices to pharmacy providers on Friday of each week for all claims submitted through the POS online pharmacy claims processing system and for all batch and paper claims. The Contractor shall pay within twenty (20) calendar days of receipt ninety- five percent (95%) of all clean claims submitted by network and non-network pharmacy providers through POS, batch electronic and paper claims submission. The term "pay" means that the Contractor shall

either send the provider cash or cash equivalent in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by that provider to the Contractor. Thereafter, the Contractor shall pay the remaining five percent (5%) of clean claims within ten (10) calendar days. The Contractor must pay the claim or advise the provider that a submitted claim is: (1) a "denied claim" (specifying all reasons for denial); or, (2) a claim that cannot be denied or allowed due to insufficient information and/or documentation (specifying in detail all information and/or documentation that is needed from the provider in order to allow or deny the claim). Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing. The Contractor shall develop, maintain and distribute to pharmacy providers a pharmacy procedure and billing manual. These manuals shall provide instructions to providers in the process by which the provider receives payment, in order to diminish the potential for incorrect billing and the need for adjustments or recoupments.

d. The Contractor shall be responsible for processing all TennCare pharmacy claims through a POS system using the specified, current NCPDP format. Pharmacy claims shall be priced and adjudicated in an online, real time POS system that results in a claim pay status of pay, suspend, or deny. The pharmacy can initiate a reversal (void) of a submitted claim. The telecommunications system supporting the POS function must be available for claims submissions by pharmacies 24 hours a day, 7 days a week (except for regularly scheduled and separately approved downtimes). TennCare providers are responsible for purchasing POS hardware, software and all telecommunications linkages. POS shall be required of all pharmacy providers. Long term care pharmacy providers and the Tennessee Department of Health may submit batch claims as described herein.

e. The Contractor must have a procedure to, on a daily basis, maintain and update enrollee profiles with information including, but not limited to, eligibility, prescriptions submitted for adjudication to TennCare, other prescriptions, over-the-counter medications, diagnosis codes, etc. As a part of TennCare reform efforts, TennCare intends to eliminate OTC drug coverage for all adults, with the exception of prenatal vitamins for pregnant women. OTC drugs for children and prenatal vitamins for pregnant women will only be covered to the extent that they are prescribed by a health care provider legally qualified to write prescriptions. Upon notification by TennCare that these provisions of the reform effort have gone into effect and communication from TennCare to the Contractor concerning the identification of eligible enrollees utilizing the standard HIPAA 834 transaction as defined in the TennCare Companion Guide, the Contractor must have appropriate processes in place to assure that OTC drugs are only reimbursed under the circumstances described above.

4. Amend Section A.2.2.2.b by deleting the entire section and substituting with the following:

b. The Contractor must establish a mail room that shall receive paper and batch electronic claims. The Contractor shall microfilm or otherwise image all payment requests, payments, and their related documents, adjustments, voids, prior authorizations and other documents. The microfilm/image shall be the permanent record of the claim.

The Contractor shall open all returned mail from any mailings to enrollees or providers to determine if the enrollee has moved, if the Contractor has the wrong

address and/or if the enrollee is communicating information to the Contractor or to TennCare. The Contractor shall track returned mail and shall report monthly, in a yet to be determined mutually agreed upon format, to the TennCare Bureau the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. Included in this report shall be a list of all enrollees whose mail was undeliverable due to an incorrect address provided by TennCare.

Failure to report monthly to the Bureau or to open and appropriately manage returned mail may result in liquidated damages as provided in Attachment A.

5. Amend Section A.2.2.2.e by deleting the entire section and substituting with the following:

e. The Contractor will assist TennCare in generating Medicaid quarterly drug rebate invoices by providing the designated TennCare staff monthly encounter data files that contain the specific information and in the specified format. These monthly encounter data files will be provided to TennCare no later than the fifteenth (15^{th}) day of each month.

6. Amend Section A.2.2.2.f by deleting the entire section and substituting with the following:

f. The Contractor must provide to the agency or business of the state's choosing, any and all appropriate, accurate, and balanced pharmacy level claims data needed to resolve or avoid any Medicaid or supplemental drug rebate disputes. This pharmacy level claims data will be provided within fifteen (15) business days of the request by TennCare.

7. Amend Section A.2.2.2.h by deleting the entire section and substituting with the following:

h. The Contractor will provide TennCare with TennCare-POS statistics of transactions between the "switches" and the Contractor related to any and all downtime associated with the Contractor's pharmacy claims processing system. Contractor must report to TennCare immediately (within two hours) upon knowledge of unscheduled or unapproved downtime. Transaction reports will include: volume, longest response time and average response time. Statistics will be provided to TennCare within ten (10) business days following the end of each calendar month.

The Contractor shall issue a report to TennCare within two (2) hours upon knowledge of downtime. Transaction reports are due ten (10) business days after end on month of reporting period. Failure to report as provided herein may result in liquidated damages as provided in Attachment A.

8. Amend the Contract by adding the Section A.2.2.2.i which will read as follows:

i. The Contractor shall ensure that collection letters are sent to contracting pharmacies which maintain an accounts-payable balance to the State greater than ninety (90) days. These notices shall be sent within five (5) workdays of becoming ninety (90) days old. Mailing and printing costs for these letters shall be a reimburseable pass-through from TennCare.

Failure to send the notices as scheduled may result in liquidated damages as provided in Attachment A.

9. Amend the Contract by adding the Section A.2.2.2.j which will read as follows:

j. The Contractor shall ensure that written notification is sent to Drug Manufacturers concerning forty-five (45) day past-due undisputed account balances within fifty (50) days after the original invoice date.

The Contractor shall also ensure that written notification is sent to Drug Manufacturers concerning seventy-five (75) day past-due undisputed account balances within eighty (80) days after the original invoice date. This notice shall remind the labeler that interest will be assessed on all past due accounts as stipulated by their contract with the State.

Failure to send the notices as scheduled may result in liquidated damages as provided in Attachment A.

10. Amend the Contract by adding the Section A.2.2.2.k which will read as follows:

k. The Contractor shall ensure that all Drug Manufacturers are invoiced for interest as stipulated in each Manufacturer's respective Supplemental Drug Rebate Contract. Interest shall be calculated on only the Manufacturer's undisputed account balance unless written notification is provided by TennCare to do otherwise. Contractor shall provide TennCare with a monthly report of remitted checks as stipulated.

Failure to charge interest as scheduled may result in liquidated damages as provided in Attachment A.

11. Amend the Contract by adding the Section A.2.2.2.l which will read as follows:

l. The Contractor shall provide TennCare Fiscal Services Unit a report detailing all checks remitted to contracted pharmacies on behalf of the State which remain outstanding (which have not been cashed) greater than ninety (90) days.

Failure to report to TennCare as scheduled may result in liquidated damages as provided in Attachment A.

12. Amend Section A.2.2.3.h by deleting the entire section and substituting with the following:

h. Recipient Validation - The system must approve for payment only those claims for members eligible to receive pharmacy services at the time the service was rendered. TennCare shall transmit eligibility/enrollment information to the Contractor via the standard HIPAA 834 transaction as defined by the TennCare Companion Guide. TennCare shall be responsible for assuring that the eligibility file provided is accurate and complete. The Contractor must use this information to immediately (within two (2) business days) identify individuals whose enrollment status has changed, update the eligibility information in the Contractor's data system, and take appropriate action as outlined below. The NCPDP 1.1 formats must be used for encounter reporting sent to TennCare. If

the Contractor has been billed for any claims for a recipient who was deceased at the time the service was allegedly provided or who is no longer eligible for TennCare, then the Contractor is required to recoup monies paid to any provider and to repay any monies collected by the Contractor for the claims that were paid post date of death or post eligibility for enrollment. The Contractor shall report monthly the amount recouped by the Contractor and the amount to be repaid to TennCare. In addition, the Contractor shall reimburse TennCare monthly for monies owed to TennCare as a result of billing for recipients not eligible to receive services.

Failure to report monthly and/or reimburse TennCare monthly may result in liquidated damages as provided in Attachment A.

13. Amend Section A.2.2.3 by adding the following sections:

p. Phase I shall include the following edits:

Script Limit Edit
This claim limit restricts the maximum number of claims per month that certain, specified recipients can receive under the TennCare benefit. A "hard" limit restricts dispensing to the specified limit with the exception of drugs included on a shortlist developed by TennCare. TennCare shall transmit eligibility/enrollment information to the Contractor via the standard HIPAA 834 transaction, as defined by the TennCare Companion Guide. The Contractor must use this information to immediately (no more than two (2) business days) identify those enrollees who have no limits, have no pharmacy benefit, or are subject to limits, and make necessary systems changes to process claims accordingly. The NCPDP 1.1 formats must be used for encounter reporting sent to TennCare.

Tiered Co-pay Edit
A tiered co-pay structure shall be coded into the POS system. Initially, only two tiers may be established. A more complex structure may be required by TennCare at a later date without any additional implementation or pre-operational compensation due to the Contractor.

Step Therapy
PDL management identifies and promotes the use of the most cost-effective drug therapy within a therapeutic class; step therapy promotes the use of the most cost-effective therapy for a specific indication, regardless of drug class. The POS system shall be coded to edit on all drugs in the target classes which are being submitted for dispensing. There shall need to be evidence in the claims history of prior use of a drug in a more cost-effective class before the new drug can gain approval through a prior authorization. Also included in this enhancement is the establishment of prior authorization criteria that cannot be handled with system edits but shall require calls to the Contractor's call center. The Contractor shall be responsible for making recommendations to TennCare regarding the need for such criteria and for subsequent criteria and call center protocol development. To the extent these criteria are not associated with drugs in categories reviewed for the PDL, the call center rates specified in Attachment B shall apply. The Contractor shall assure that call center staff shall be available to evaluate prior authorization requests per the standards required in section A.3.5.1 and A.3.5.3 of the contract. An agreed upon set of edits/PA criteria in this category shall be implemented during Phase II. Additional edits of this type shall be implemented at TennCare's direction at any point in the term of the Contract without additional implementation or pre-operational compensation due

to the Contractor. While the Contractor shall recommend possible step therapy edits or Prior Authorization criteria for review by the Pharmacy Advisory Committee, the State shall have final decision on method and timing of implementation.

Gross Amount Due (GAD) Edit
As defined by TennCare.

Drug to Gender Edit
Any medication which is specifically indicated for either a male or female shall reject at the point of service if the medication is prescribed for a patient of the opposite gender.

Maximum Dollar Amount Edit
All pharmacy claims over a specified dollar amount per claim shall reject at the point of service and shall require the pharmacy provider to call the First Health Services Call Center. This includes a $250 limit on compounded claims, a $10,000 limit on non-compounded, non-exception claims, a $2,500 limit on Total Parenteral Nutrition (TPN) products and a $50,000 limit on exception claims (blood factors and other identified products).

DEA Number Edit
The claims processing system shall be set to deny for all controlled substances where the DEA number used is not active in the National DEA file (NTIS) used by the Contractor.

Drug Dosage and Dose Optimization Edit
The dose optimization edit shall assess the tablet strengths of a drug and assure that the most cost-effective strength is dispensed. Appropriate selection shall assist in minimizing the cost of therapy. The POS system shall be coded to limit the quantity per prescription to ensure the most cost-effective strength is dispensed. Also, where there are appropriate concerns with respect to over-utilization of medications, quantity limits shall be entered into the system. The pharmacy shall receive a hard denial for any claim that exceeds the limit. A prescriber must obtain a prior authorization in order for the claim to process through the system.

An agreed upon set of edits in this category shall be implemented during Phase II. Additional edits of this type shall be implemented at TennCare's direction at any point in the term of the Contract without additional implementation or pre-operational compensation due to the Contractor.

Drug Duplication of Therapy Edit
This edit automatically identifies and reports problems that involve therapeutic duplications of drugs when the submitted claim is associated with other drugs or historical claims identified for a given enrollee.

OTC Drug Coverage Elimination
TennCare intends to eliminate OTC drug coverage for all adults, with the exception of prenatal vitamins for pregnant women. OTC drugs for children and prenatal vitamins for pregnant women will only be covered to the extent that they are prescribed by a health care provider legally qualified to write prescriptions.

q. Phase II shall include the following edits:

Unit of Measure Edit

The Unit of Measure (UOM) edit shall perform two main functions:

a) check incoming claim units (i.e. gram, ml, etc) versus the units listed in First Databank for that particular NDC

b) verify that the unit amounts transmitted are consistent with the unit amounts in First Databank (The submitted quantity must be a multiple of the unit size shown in FirstDatabank. i.e. claim shall be rejected if unit amount transmitted has been rounded, - example - units transmitted is 14, but unit amount is 13.7 in First Databank)

MAC/DAW

This edit requires medical justification to be provided for a Branded product when a generic substitute is available. When a prescriber writes a prescription for a multi-source product and requests that the prescription be Dispensed As Written (DAW), the pharmacist uses the DAW edit to allow dispensing of the brand, but the claim shall only pay at the lower payment (MAC). The pharmacist shall call the prescriber and change the prescription to an alternate agent. If the prescriber will not change to an alternate agent, then the prescriber or prescriber's agent must call for a prior authorization.

Definition of MAC

The pricing of claims is driven by the pricing methodologies described by TennCare rules and policies**.** The system must compare the calculated allowed (i.e., quantity multiplied by price plus the dispensing fee) to the billing charge and authorize payment based on the current TennCare pricing methodology. Most generic drugs and multisource products shall be assigned Maximum Allowable Cost (MAC) prices by the federal government or by TennCare. The Contractor's system must allow for such MAC price changes, as well as any other price adjustments, to be made online, real time by the TennCare Pharmacy Director or his/her appropriate staff on the day requested. NCPDP overrides at the POS level must be available to the dispensing pharmacist in the event a DAW (dispense as written) override is necessary and allowed or required by TennCare policy.

As of January 1, 2005, TennCare's claim pricing is based on the MAC pricing provided by the Contractor. During Phase II implementation, the Contractor shall change certain MACs at the direction of TennCare, provided that the Contractor can confirm that the drugs can be acquired for such prices. The Contractor shall be responsible for ongoing MAC pricing maintenance and provider appeals related to those changes. Subsequent changes may be implemented upon the direction of TennCare after completion of Phase II implementation without additional implementation or pre-operational compensation due the Contractor, provided the total number of drugs involved in such changes does not exceed one hundred (100) drugs (drug equals Generic Sequence Number or GSN).

r. Phase III shall include the following edits:

Prescriber Last Name Edit

The claims processing system shall be set to ensure that the submitted prescriber last name correctly matches the last name associated with the submitted DEA number that is present on the National DEA file (NTIS) used by the Contractor.

Drug Duration Edit

Duration of Therapy is performed to determine whether the current prescription exceeds the recommended maximum days supply for that drug and is based on commonly used drug and clinical data.

Drug to Disease Edit
This edit automatically identifies and reports problems which involve use of drugs contraindicated by inferred diagnosis codes on current and historical claims for a given enrollee.

Drug-Drug Interaction Edit
This edit automatically identifies and reports problems that involve use of drugs contraindicated by other drugs on current and historical claims for a given enrollee. Also, it automatically indicates and reports on the level of severity of the drug/drug interaction.

Throughout implementation of all phases, the Contractor shall review children's prescriptions at POS to screen for possible fraudulent attempts by adult recipients to obtain prescriptions for themselves. The Contractor and TennCare staff shall agree upon criteria to produce a retrospective report containing such findings with recommendations for prevention of such practices.

The Contractor guarantees that the implementation of the above named initiatives will result in cost savings for TennCare equal to or greater than the implementation and monthly administration fees associated with these initiatives. Contemporaneous with the implementation of the various savings initiatives, the parties shall negotiate and mutually agree upon the necessary assumptions, the formula for calculating the baseline and resultant savings, and any incentive to which the contractor may be entitled for exceeding the agreed upon savings.

Failure to meet deadlines in Phase I, Phase II or Phase III or to perform as required by the Contract shall result in liquidated damages as set out in Attachment A of the Contract.

14. Amend Section A.2.2.4.b by deleting the entire section and substituting with the following:

b. The pricing of claims is driven by the pricing methodologies described by TennCare rules and policies**.** The system must compare the calculated allowed (i.e., quantity multiplied by price plus the dispensing fee) to the billing charge and authorize payment based on the current TennCare pricing methodology. Most generic drugs and multisource products shall be assigned Maximum Allowable Cost (MAC) prices by the federal government or by TennCare. The Contractor's system must allow for such MAC price changes, as well as any other price adjustments, to be made online, real time by the TennCare Pharmacy Director or his/her appropriate staff on the day requested. NCPDP overrides at the POS level must be available to the dispensing pharmacist in the event a DAW (dispense as written) override is necessary and allowed or required by TennCare policy.

As of January 1, 2005, TennCare's claim pricing is based on the MAC pricing provided by the Contractor. During Phase II implementation, the Contractor shall change certain MACs at the direction of TennCare, provided that the Contractor can confirm that the drugs can be acquired for such prices. The Contractor shall be responsible for ongoing MAC pricing maintenance and provider appeals related to those changes. Subsequent changes may be implemented upon the direction of TennCare after completion of Phase II implementation without

additional implementation or pre-operational compensation due the Contractor, provided the total number of drugs involved in such changes does not exceed one hundred (100) drugs (drug equals GSN).

15. Delete Section A.2.2.4.f in its entirety.

16. Amend Section A.2.2.6 by deleting the entire section and substituting with the following:

Reversals and Adjustments. The system must provide an efficient means of reversing or adjusting claims both before and after the claim has been transmitted to the TCMIS. The result of the adjustment must be transferred to TCMIS for further processing. TennCare will make no payments to the Contractor for reversed, voided or adjusted claims. Contractor shall process all reversals requested by TennCare fiscal within 30 days and provide confirmation to TennCare fiscal that such has occurred.

Failure to reverse or adjust claims within 30 days may result in liquidated as provided in Attachment A.

17. Amend Section A.2.4.2 by deleting the entire section and substituting with the following:

A.2.4.2. Encounter Reports. Post-adjudicated claims (encounters) must be reported by the Contractor on a schedule designated by TennCare. The current schedule is weekly. The NCPDP 1.1 formats must be used for encounter reporting sent to TennCare.

Failure to report post-adjudicated claims (encounters) to TennCare weekly as directed by TennCare may result in liquidated damages as provided in Attachment A.

18. Amend Section A.3.1.10 by deleting the entire section and substituting with the following:

The Contractor will support the management and coordination of all activities related to the maintenance of the TennCare PDL. Activities will include but not be limited to the following:

- The Contractor will present the TennCare Pharmacy Advisory Committee clinical reviews of new brand-name drugs and new generic drugs for clinical safety and efficacy, and make recommendations regarding possible inclusion in the TennCare PDL.
- The Contractor will present the TennCare Pharmacy Advisory Committee clinical review of existing drugs for new indications or changes to indications that might affect their inclusion in the TennCare PDL.
- The Contractor will annually review drugs within chosen therapeutic classes in order to affirm or change the recommendations to TennCare regarding supplemental rebate strategies.
- The Contractor will develop changes to drug review criteria for the TennCare PDL based on new clinical and pharmacoeconomic information.
- The Contractor will analyze cost information relative to drug alternatives as they affect the TennCare PDL.

Purpose and Scope of Reviews

- The primary function of the PDL drug class review is to assist the Committee members in determining if the drugs within the therapeutic class of interest can be considered therapeutic alternatives.

- PDL decisions are limited to *within* class comparisons—unlike a hospital or MCO formulary drug review (which is usually drug-specific and not class-specific), PDL drug class reviews usually have limited data concerning the drug class's place in therapy or comparisons to other drugs outside the drug class in question.

- These reviews not designed to be used for other purposes such as development of DUR criteria, prospective edits, step therapy edits, etc.

Disclaimer Printed on Drug Class Review

- The clinical information contained herein is provided for the express purpose of aiding the Pharmacy and Therapeutics ("P&T") Committee members in reviewing medications for inclusion in or exclusion from the Preferred Drug List.

- This information is not intended nor should it be used as a substitute for the expertise, skill, and judgment of physicians, pharmacists, or other healthcare professionals.

- The absence of a warning for any given drug or drug combination should not be construed to indicate that the drug or drug combination is safe, appropriate or effective for any given patient.

- This information is intended to supplement the knowledge and additional resources available to the P&T Committee members and should not be considered the sole criteria used by the P&T Committee in deciding what medications will be included or excluded from the Preferred Drug List.

- The Contractor will monitor compliance by prescribers and pharmacists with the TennCare PDL, report that information to TennCare monthly and quarterly, and semiannually, and provide suggestions for improving PDL compliance.

The Contractor shall create and forward a PDL Bonus Payment Report which shall outline the percentage of prescriptions dispensed which have adhered to the PDL during the previous six (6) month period. This Report shall be sent directly to TennCare Fiscal Services Unit within forty-five (45) days following the period but not earlier than thirty (30) days following the period.

Failure to provide this report as directed by TennCare may result in liquidated damages as provided in Attachment A.

19. Amend Section A.3.1.11 by deleting it in its entirety and substituting the following:

A.3.1.11. The Contractor will attend, support and facilitate meetings of the TennCare Pharmacy Advisory Committee as necessary to maintain the TennCare PDL. Such support will include responsibility to taking minutes at all Pharmacy Advisory Committee meetings.

20. Amend Section A.3.3.1 by deleting it in its entirety and substituting the following:

A.3.3.1. The Contractor shall develop and implement an effective education program for providers (prescribers and pharmacists) that explains how the TennCare PDL and prior authorization programs operate. The education program initiative must begin prior to the effective date of the TennCare PDL and prior authorization programs and continue on an ongoing basis. On an ongoing basis this education program will include interventions with providers and pharmacists to improve compliance with the PDL.

21. Amend Section A.3.8. (f) by deleting it in its entirety and substituting the following:

f. Quarterly reports demonstrating the nature and extent of educational interventions to outlier prescribers and pharmacists and the outcomes of those interventions.

22. Amend Section A.3.6 by deleting the entire section and substituting with the following:

A.3.6 Staff Dedicated to TennCare

Pharmacy Clinical Manager
The Contractor shall provide a Pharmacy Clinical Manager to offer clinical program support to TennCare. The Clinical Manager assigned to this project must be a licensed pharmacist with a Doctor of Pharmacy degree from an accredited pharmacy school and approved by TennCare. If it becomes necessary for the Contractor to replace the Clinical Manager, the Contractor shall notify TennCare within three (3) business days of the change.

Pharmacy Contract Project Director and Staff
The Contractor shall designate and maintain, subject to TennCare approval, a Project Director for this Contract who has day-to-day authority to manage the total project. The Project Director shall be readily available to TennCare staff during regular working hours by working onsite within the TennCare Bureau. The Contractor's staff addressed herein shall be available to attend meetings as requested by TennCare. TennCare shall provide office space for the Contractor's onsite Pharmacy Project Director. The Contractor shall maintain sufficient levels of staff including supervisory and support staff with appropriate training, work experience, and expertise to perform all contract requirements on an ongoing basis including but not limited to the following personnel, all of whom must be dedicated 100% to TennCare:

a. one (1) clinical pharmacist located in Nashville,
b. two (2) provider educator pharmacists located in Nashville,
c. one (1) pharmacy research scientist located in Nashville,
d. one (1) data quality analyst located in Nashville,
e. one (1) system liaison located in Richmond and available in Nashville upon request from TennCare,
f. one (1) contract manager located in Richmond,
g. one (1) business analyst located in Richmond,
h. one (1) project manager to address program changes based 25% in Nashville and 75% in Richmond.

i. two (2) mail room clerks located in Richmond.

Telephone and administrative personnel shall be familiar with covered services under the TennCare pharmacy program and other member eligibility prerequisites. TennCare shall have the right to approve the Project Director and any other key positions. TennCare shall have the right to require removal, in writing, from this Contract of any staff found unacceptable to TennCare with cause. TennCare shall be notified within three (3) business days of key staffing changes and name changes and TennCare shall have the right to approve any such changes. The Project Director shall provide overall project coordination between the clinical and operational aspects in support to TennCare. If it becomes necessary for the Contractor to replace the Project Director, the Contractor shall notify TennCare within three (3) business days of the change and TennCare shall approve any such changes.

23. Amend the Contract by adding Section A.3.9 which will read as follows:

The Contractor shall have the technical capability to remove drugs from the PDL as requested by TennCare.

Failure to remove drugs from the PDL within the time as specified by TennCare will result in penalties assess equal to the cost of said drug from the date established by TennCare and the date implemented.

24. Amend Section A.11 by deleting the entire section and substituting with the following:

A.11. TennCare Member Identification Cards

The Contractor shall provide each TennCare member with a permanent pharmacy benefit identification card by February 1, 2004. The card shall comply with all state laws and NCPDP guidelines regarding the information required on the card. The card shall also list any appropriate copays for the member, an effective date for the card, and any other information required by TennCare. The Contractor shall provide pharmacy benefit identification cards for new TennCare members added to the TennCare eligibility file and members whose benefit limits have changed on an ongoing basis. The cards shall be produced and mailed by the Contractor on the 15th day of each month. To the extent that the reissue of TennCare Member Identification Cards is necessary to implement pharmacy reform (including prescription limits and tiered co-pays), the Contractor must assure that all enrollees receive their new ID cards at least fifteen (15) days prior to the planned implementation date.

The Contractor shall be reimbursed for costs as acceptable and approved by TennCare and which relate to the production or replacement of the identification cards. The Contractor must invoice TennCare in writing and must delineate the actual costs incurred. TennCare has the final approval on payment of the invoice.

Mailings pursuant to this Section of the Contract shall be mailed first class unless otherwise approved or directed by the State. The direct postage cost shall be a pass-through item and shall not include Contractor postage for Contractor business operations. The State shall reimburse the Contractor for actual costs.

The Contractor shall open all returned mail from any mailings to enrollees or providers to determine if the enrollee has moved, if the Contractor has the wrong address, and/or if the enrollee is communicating information to the Contractor or to TennCare. The

Contractor shall track returned mail and shall report monthly to the TennCare Bureau the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. Included in this report shall be a list of all enrollees whose mail was undeliverable due to an incorrect address provided by TennCare.

Failure to report monthly to the Bureau or to open and appropriately manage returned mail may result in liquidated damages as provided in Attachment A.

25. Amend Section A.14 of the Contract by deleting it in its entirety and substituting the following:

A.14. The Emergency Supply Override

The Contractor shall assure that the TennCare-POS system allows pharmacists to execute an emergency or "*Grier* Override" that shall process an emergency supply of drugs in normally covered therapeutic categories that are not listed on the TennCare PDL. The Contractor's TennCare-POS system must post a message for the dispensing pharmacist to contact the prescriber, so that the pharmacist can suggest alternative therapies listed on the TennCare PDL. Drugs eligible for the emergency or *Grier* Override must be in a therapeutic class normally covered by TennCare. The Contractor shall instruct pharmacy providers how to perform the *Grier* Override in the National Council of Prescription Drug Programs (NCPDP) environment of the TennCare-POS pharmacy claims processing system.

If TennCare determines that modification of the Grier override system is necessary to comply with changes in the consent decree or to control pharmacy costs in a manner consistent with the current consent decree, the Contractor shall make such modifications as directed by TennCare. A requirements session will be conducted to identify the required logic, a business plan shall be developed, and the changes shall be implemented after sufficient time has been allotted for coding and testing of all changes. Such coding changes shall be compensated at the System Change Request hourly rate.

Failure by the Contractor to allow the POS emergency or *Grier* Override for all appropriate, emergency claims may result in the assessment of liquidated damages by TennCare of two hundred dollars ($200) per day during the first month violations are identified. Liquidated damages will increase to four hundred dollars ($400) per day for the second consecutive month violations are identified. TennCare will monitor emergency or *Grier* Overrides and notify the Contractor of any violations as well as any possible sanctions related to those violations. The Contractor will have seventy-two (72) hours, following written notification, to correct all violations prior to assessment of liquidated damages by TennCare. The Contractor shall submit to TennCare, within twenty-four (24) hours, a written corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

26. Amend Section C.1 by deleting the entire section and substituting with the following:

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Thirty-Seven Million Nine Hundred Thousand Dollars ($37,900,000.00) *The* Service Rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment

required. The Service Rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor. Notwithstanding the above, the Contractor shall be reimbursed for any "pass-through" costs for which the parties have agreed.

In the event the maximum liability is to be exceeded because of unanticipated volumes of activity payable on a per unit basis hereunder, then Contractor shall promptly notify TennCare in writing so that TennCare can adjust the amount of this maximum liability provision. Contractor shall have no obligation to continue to provide services at any time the maximum liability, as adjusted, has been exceeded.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the Service Rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

27. Amend Section C.3 by deleting the entire section and substituting with the following:

C.3. Payment Methodology. The Contractor shall be compensated based on the Service Rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1. The Contractor's compensation shall be contingent upon the satisfactory completion of units of service or project milestones defined in Section A. The Contractor shall be compensated based upon the following Service Rates:

Monthly Fee Year 1 $484,500.00
Monthly Fee Year 2 $346,750.00
Monthly Fee Year 3 $351,500.00
Monthly Fee Year 4 (if renewed by amendment) $356,250.00
Monthly Fee Year 5 (if renewed by amendment) $361,000.00

In addition to the monthly fee, TennCare will compensate the Contractor as provided herein in accordance with specified rates in Attachment B and Attachment C. The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall at a minimum, include:

the numbers and types of pharmacy claims adjudicated; separately itemized actual payments made to pharmacy service providers for each pharmacy claim adjudicated; subtotal for all pharmacy claims adjudicated; subtotal of all actual payments; the comprehensive monthly fee in effect, and the total amount due to the Contractor for the period invoiced.

28. Amend Section E.4 by deleting the entire section and substituting with the following:

E.4. Breach. A party shall be deemed to have breached the Contract if any of the following occurs:

- failure to perform in accordance with any term or provision of the Contract;
- partial performance of any term or provision of the Contract;
- any act prohibited or restricted by the Contract; or
- violation of any warranty.

For purposes of this Contract, and any amendments entered herein, these items shall hereinafter be referred to as a "Breach."

a. Contractor Breach— The State shall notify Contractor in writing of a Breach.

(1) In event of a Breach by Contractor, the state shall have available the remedy of Actual Damages or assessed penalties up to the maximum limits provided herein and, in addition, any nonmonetary remedy available at law or equity.

(2) Partial Default— In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of: (1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State shall begin to provide the service associated with the Breach. In the event of a Partial Default, the parties shall negotiate the appropriate compensation payable to Contractor. In the absence of agreement on compensation for such reduced services, either party may terminate the contract for convenience upon thirty (30) days notice.

Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor.

In the event the State declares a Partial Default, the State may withhold, together with any other damages associated with the Breach, from the amounts due the Contractor the greater of: (1) amounts which would be paid the Contractor to provide the defaulted service; or (2) the cost to the State of providing the defaulted service, whether said service is provided by the State or a third party. To determine the amount the Contractor is being paid for any particular service, the Department shall be entitled to receive within five (5) days any requested material in its then existing format from Contractor. The State shall make the final and binding determination of said amount.

The State may assess Liquidated Damages against the Contractor for any failure to perform which ultimately results in a Partial Default with

said Liquidated Damages to cease when said Partial Default is effective (see Attachment A). Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor agrees to cooperate fully with the State in the event a Partial Default is taken. The amount of these liquidated damages assessed against the Contractor shall be in accordance with the specific penalty provisions contained herein but shall not exceed ten per cent of the amount previously paid by TennCare to Contractor for services provided under the Contract.

(3) Contract Termination— In the event of a Breach, the State may terminate the Contract immediately.. The Contractor shall be notified of the termination in writing by the State. Said notice shall hereinafter be referred to as Termination Notice. The Termination Notice may specify either that the termination is to be effective immediately, on a date certain in the future, or that the Contractor shall cease operations under this Contract in stages. In the event of a termination, the State may withhold any amounts which may be due Contractor without waiver of any other remedy or damages available to the State at law or at equity. The Contractor shall be liable to the State for any and all damages incurred by the State and any an all expenses incurred by the State which exceed the amount the State would have paid Contractor under this Contract. Contractor agrees to cooperate with the State in the event of a Contract Termination or Partial Takeover.

b. State Breach— In the event of a Breach of contract by the State, the Contractor shall notify the State in writing within thirty (30) days of any Breach of contract by the State. Said notice shall contain a description of the Breach. Failure by the Contractor to provide said written notices shall operate as an absolute waiver by the Contractor of the State's breach. In no event shall any Breach on the part of the State excuse the Contractor from full performance under this Contract. In the event of Breach by the State, the Contractor may avail itself of any remedy at law in the forum with appropriate jurisdiction; provided, however, failure by the Contractor to give the State written notice and opportunity to cure within thirty (30) days of receipt of the breach notice as described herein operates as a waiver of the State's Breach. Failure by the Contractor to file a claim before the appropriate forum in Tennessee with jurisdiction to hear such claim within one (1) year of the written notice of Breach shall operate as a waiver of said claim in its entirety. It is agreed by the parties this provision establishes a contractual period of limitations for any claim brought by the Contractor.

29. Amend the Contract by adding a new section E.20 which will read as follows:

State Interest in Equipment – Uniform Commercial Code Security Agreement

The Contractor shall take legal title to all equipment purchased totally or in part with funds provided under this Amendment, subject to the State's equitable interest therein, to the extent of its *pro rata* share, based upon TennCare's contribution to the purchase price. "Equipment" shall be defined as an article of nonexpendable, tangible, personal property which (i) has a useful life of more than one year, (ii) has an acquisition cost which equals or exceeds five thousand dollars ($5,000.00) and (iii) is used exclusively in the performance of this Contract.

As authorized by the provisions of the terms of the Tennessee Uniform Commercial Code – Secured Transaction, found at Title 47, Chapter 9 of the ***Tennessee Code Annotated***, an intent of this Amendment and the parties hereto is to create and acknowledge a security interest in favor of TennCare in the Equipment acquired by the Contractor pursuant to the provisions of this Amendment.

The Contractor hereto grants TennCare a security interest in said Equipment. This agreement is intended to be a security agreement pursuant to the Uniform Commercial Code (UCC) for any Equipment herein specified which, under applicable law, may be subject to a security interest pursuant to the UCC, and the Contractor hereby grants TennCare a security interest in said equipment. The Contractor agrees that TennCare may file this Amendment, or a reproduction thereof, in any appropriate office, as a financing statement for any of the equipment herein specified. Any reproduction of this or any other security agreement or financing statement shall be sufficient as a financing statement. In addition, the Contractor agrees to execute and deliver to TennCare, upon the request of TennCare, any financing statements, as well as extensions, renewals, and amendments thereof, and reproduction of this Amendment in such form as TennCare may require to perfect a security interest with respect to said Equipment. The Contractor shall pay all costs of filing such financial statements and any extensions, renewals, amendments and releases thereof. Without prior written consent of TennCare, the Contractor shall not create or suffer to be created pursuant to the UCC, any other security interest in said Equipment, including replacements and additions thereto. Upon the Contractor's breach of any covenant or agreement contained in this Amendment, TennCare shall have the remedies of a secured party under the UCC and, at TennCare's option, may also invoke remedies herein provided.

The Contractor agrees to be responsible for the accountability, maintenance, management, and inventory of all property purchased totally or in part with funds provided under this Amendment. The Contractor shall maintain a perpetual inventory system for all Equipment purchased with funds provided under this Amendment and shall submit and inventory control report which must include, at a minimum, the following:

a. Description of the Equipment;
b. Manufacturer's serial number or other identification number, when applicable;
c. Consecutive inventory Equipment tag identification;
d. Acquisition date, cost, and check number;
e. Percentage of State funds applied to this purchase;
f. Location within the Contractor's operations where the Equipment is used;
g. Condition of the property or disposition date if Contractor no longer has possession;
h. Depreciation method, if applicable; and
i. Monthly depreciation amount, if applicable.

The Contractor shall notify TennCare, in writing, of any Equipment loss describing reason(s) for the loss. Should the Equipment be destroyed, lost, or stolen, the Contractor shall be responsible to TennCare for the *pro rata* amount of the residual value at the time of loss based upon TennCare's original contribution to the purchase price, unless Contractor chooses to replace the Equipment at its own cost to continue performance under the Contract.

Upon termination of the Contract, where a further contractual relationship is not entered into, or at another time during the term of the Contract, the Contractor shall request written approval from TennCare for any proposed disposition of Equipment purchased pursuant to this Amendment. All Equipment shall be disposed of in such manner as

parties may agree from among alternatives approved by Tennessee Department of General Services and in accordance with any applicable federal laws or regulations.

30. Amend the Contract by adding Section E. 21 which will read as follows:

Performance Reviews. Contractor shall cooperate with any performance review conducted by TennCare, including providing copies of all records and documentation arising out of Contractor's performance of obligations under the Contract or its Amendments. Upon reasonable notice, TennCare may conduct a performance review and audit of Contractor to determine compliance with the Contract and its Amendments. At any time, if TennCare identifies a deficiency in performance, liquidated damages as specified herein may be assessed, and the Contractor will be required to develop a Corrective Action Plan to correct the deficiency including an explanation of how TennCare members will continue to be served until the deficiency is corrected.

TennCare reserves the right to conduct on-site audits and reviews with reasonable notification to the Contractor.

31. Delete Attachment A in its entirety and replace with revised Attachment A.

32. Add Attachments B and C.

The other terms and conditions of this contract not amended hereby shall remain in full force and effect.

IN WITNESS WHEREOF:

FIRST HEALTH SERVICES CORPORATION:

Teresa R. DiMarco, President
Date

DEPARTMENT OF FINANCE AND ADMINISTRATION, TENNCARE BUREAU

M. D. Goetz, Jr., Commissioner
Date

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr., Commissioner
Date

COMPTROLLER OF THE TREASURY:

John G. Morgan, Comptroller of the Treasury
Date

ATTACHMENT A

LIQUIDATED DAMAGES FOR PERFORMANCE MEASURES

PERFORMANCE MEASURE	REPORTING REQUIREMENT	DELIVERABLE	PENALTY
A.1.1 Program Enhancements	Within thirty (30) days of signature of this Amendment, the Contractor shall develop a report format for TennCare review and approval. Said report shall be designed to provide TennCare with monthly updates regarding the cost savings attributed to each program enhancement included in this Amendment. Following TennCare approval of the report format, said report shall be generated monthly and posted in First Decision.	Within thirty (30) days of signature of Amendment, report format is due for TennCare review. Reports due monthly, ten (10) business days after end of month of reporting period, beginning for the first full month after the report format has been agreed to FirstIQ reports are due monthly, fifteen (15) days after the end of the monthly reporting period.	Damages will be assessed weekly. Calculation of the damages will begin on the first day following the report due date and will continue until receipt of the report by TennCare. Penalty will be $2,500 per week.
A.2.2.1 Claim Adjudication Services – General Requirements	The Contractor shall distribute and mail TennCare outputs as required by the contract including, but not limited to, provider checks and remittance advices, returned claims, notices, provider bulletins, provider manuals and special mailings. The Contractor shall mail checks and remittance advices to pharmacy providers each week on Fridays, with the exception of Holiday weeks. TennCare shall be notified no later than five (5) business days of any systems or operational issues that may impact disbursements by the prescribed timelines. a. Cash flow – For checks to be issued on Friday, the Contractor must deliver two files to the State, in an electronic media suitable to the		a. Cash flow – Penalty will be $1,000 per day files are overdue.

	State, by 10:00 a.m. Thursday of each week.		
A.2.2.2.b Mail Procedures	The Contractor shall open all returned mail from any mailings to enrollees or providers within 30 days of receipt to determine if the enrollee has moved, if the Contractor has the wrong address, and/or if the enrollee is communicating information to the Contractor or to TennCare. The Contractor shall track returned mail and shall report monthly to the TennCare Bureau the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. Included in this report shall be a list of all enrollees whose mail was undeliverable due to an incorrect address provided by TennCare.	Monthly report, due ten (10) business days after end of month of reporting period , beginning for the first full month after the report format has been agreed to .	Calculation of the damages will begin on the first day following the report due date and will continue until receipt of the report by TennCare. Penalty will be $2,500 per week.
A.2.2.2.e. Assistance in Generating Quarterly Drug Rebate Invoices	The Contractor shall provide designated TennCare staff quarterly encounter data files that contain the specific information and in the specified format required by TennCare to deliver the Medicaid quarterly drug rebate invoices. These quarterly encounter data files shall be provided to TennCare no later than the fifteenth (15th) day after the end of quarter. Any changes to supporting data must be provided to FirstHealth no later than 45 days prior to the end of the quarter. This includes but is not limited to Unit of Measure updates, Supplemental NDC's that should not be included in the FirstRebate extract, and valid provider list.	Quarterly files, due fifteen (15) business days after end of the quarter for reporting period.	Calculation of the damages will begin on the first day following the due date and will continue until receipt of the report by TennCare. Penalty will be $5,000 per week.
A.2.2.2.f. Drug Rebate Dispute Data	The Contractor must provide to the agency or business of the state's choosing, in its then	This data must be provided to TennCare within fifteen (15) days of a request by	Calculation of the damages will begin on the first day

	existing format, any and all appropriate, accurate, and balanced pharmacy level claims data needed to resolve or avoid any Medicaid or supplemental drug rebate disputes. This pharmacy level claims data will be provided within fifteen (15) business days upon TennCare's sign off of the final Change Control memo. If the request can not be fulfilled within 15 business days, the Contractor shall notify TennCare in writing of the delay, and a mutually agreed upon date will be determined..	TennCare	following the due date and will continue until receipt of the report by TennCare. Penalty will be $5,000 per week.
A.2.2.2.g.i. Batch Electronic Media (EMC) Claims Processing	The Contractor must receive claims in electronic format, separate tape from diskette, convert diskette to tape, schedule tapes for immediate processing and return media to submitting providers within three (3) business days. The Contractor shall assign identification control numbers to all batch claims within three (3) business days of receipt. The Contractor shall maintain electronic backup of batch claims for the duration of the contract. If TennCare requests copies of batch electronic claims, these must be provided within three (3) business days of request. As requested, the Contractor will provide the batch files as they were originally received. These files will be delivered to the TennCare site via VPN. Electronic batch claims shall be submitted through a sequential terminal, or similar method that shall allow batch and POS claims to be adjudicated through the same processing logic. New providers requesting	Return media claims to submitting providers within three (3) business days of receipt, assignment of identification control numbers to all batch claims within three (3) business days of receipt and provide TennCare with copies of batch electronic claims within three (3) business days of request.	Calculation of the damages will begin on the first day following the due date and will continue until receipt of the report by TennCare. Penalty will be $1,000 per day.

	to submit batch claims must provide at least a 30 day notice and must conform to the standard Change Control and testing process.		
A.2.2.2.g.ii. POS Claims	The Contractor shall process POS pharmacy claims within five (5) seconds. This is the time from when the claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor and shall include all procedures required to complete claim adjudication.	Five (5) seconds per processed pharmacy claim through the Contractor's POS system	If 95.5 percent of claims are not processed within the 5 second time frame then the daily penalty will be $1,000 per day of non-compliant processing.
A.2.2.2.g.iii. Paper Claims	Paper claims may include, but not be limited to, those submitted in situations when an enrollee has to visit an out-of-state pharmacy in an emergency or paper claims from any of the Tennessee Department of Health clinics. Paper claims shall be submitted on universal claim forms. The Contractor shall process and adjudicate these universal, paper claims within twenty (20) days of receipt. The Contractor shall add all pertinent drug information data to the TennCare-POS system and DUR system immediately upon processing the claim.	Paper claims must be processed within twenty (20) days of receipt.	Penalty will be $100 per day per claim in excess of the twenty (20) day processing requirement.
A.2.2.2.h. POS Downtime Notification	Contractor must report to TennCare immediately (within two (2) hours) upon knowledge of downtime. For purposes hereof "downtime" shall be any continuous one-hour period of time in which the system is not operational. TennCare is to identify staff to be contacted after normal business hours in the event of an interruption of service.	Report due immediately, within two (2) hours, upon knowledge of downtime.	Immediate report due within two (2) hours upon knowledge of the downtime. $7,500 one time damage for not reporting immediately.

A.2.2.2.h. POS Downtime Statistics	The Contractor shall provide TennCare with TennCare-POS statistics of transactions between the "switches" and the Contractor related to any and all downtime associated with the Contractor's pharmacy claims processing system. Transaction reports shall include: volume, longest response time and average response time. Statistics shall be provided to TennCare within ten (10) business days following the end of each calendar month in which any downtime occurred.	Report due ten (10) business days after end of month of reporting period in which any downtime occurred.	Daily penalty will be $1,000 per day. Calculation of the damages will begin on the first day following the due date of the report and will continue until receipt of the report by TennCare.
A.2.2.2.i	The Contractor shall ensure that collection letters are sent to pharmacies which maintain an accounts-payable balance to the State greater than ninety (90) days. These notices shall be sent within five (5) workdays of becoming ninety (90) days old.	Contractor shall provide TennCare with a monthly report of notices that had been sent. Reports due monthly, ten (10) business days after end of month of reporting period.	If Contractor fails to send notice, the penalty will be $100 per provider notice per month.
A.2.2.2.j	The Contractor shall ensure that written notification is sent to Drug Manufacturers concerning forty-five (45) day past-due undisputed account balances within fifty (50) days after the original invoice date. The Contractor shall also ensure that written notification is sent to Drug Manufacturers concerning seventy-five (75) day past-due undisputed account balances within eighty (80) days after the original invoice date. This notice shall remind the labeler that interest will be assessed on all past due accounts as stipulated by their contract with the State.	Contractor shall provide TennCare with copies of all reports sent pursuant to this section. Reports due monthly, ten (10) business days after end of month of reporting period.	If Contractor fails to send notice, the penalty will be $100 per Manufacturer per day independent of other dunning periods.
A.2.2.2.k	The Contractor shall ensure that all Drug Manufacturers are charged interest as stipulated in each Manufacturer's		Failure by Contractor to start accruing interest on the date stipulated

	respective Supplemental Drug Rebate Contract. Interest shall be calculated on only the Manufacturer's undisputed account balance unless written notification is provided by TennCare to do otherwise.		in the individual supplemental rebate agreements will result in a penalty of $1,000 for every non-compliant invoice issued.
A.2.2.2.l	The Contractor shall provide TennCare Fiscal Services Unit a monthly report detailing all checks remitted to providers on behalf of the State which remain outstanding (have not been cashed) greater than ninety (90) days.	Contractor shall provide TennCare with a monthly report of remitted checks as stipulated. Reports due monthly, due on the 15th day of the month following the reporting period.	Penalty will be $500 per week that report is overdue.
A.2.2.3.h Recipient Validation	The system must approve for payment only those claims for members eligible to receive pharmacy services at the time the service was rendered. TennCare shall transmit eligibility/enrollment information to the Contractor via the standard HIPAA 834 transaction as defined by the TennCare Companion Guide. The Contractor must use this information to immediately (within two (2) business days) identify individuals whose enrollment status has changed, update the eligibility information in the Contractor's data system, and take appropriate action as outlined below. The NCPDP 1.1 formats must be used for encounter reporting sent to TennCare. If the Contractor bills for any claims for a recipient who is deceased at the time the service was allegedly provided or who is no longer eligible for TennCare and the Contractor should have been aware of such at the time the claim was paid (i.e. the change in eligibility had been communicated to the	Monthly report due ten (10) business days following the end of the calendar month.	$1,000 for each claim processed three (3) business__ days after written or electronic notification by TennCare of recipient's death or date of ineligibility. $1,000 for each month recoupment is not made on an individual who is known to be deceased or ineligible. $500 for each week report is late. Calculation of the damages will begin on the first day following the due date and will continue until receipt of the report by TennCare.

	Contractor by TennCare via the HIPAA 834 prior to the processing of the claim), then the Contractor is required to recoup monies paid to any provider and repay TennCare for the claims post date of death or post eligibility for enrollment. If the Contractor bills for any claims for a recipient who is deceased at the time the service was allegedly provided or who is no longer eligible for TennCare and the Contractor could not have been aware of such at the time the claim was paid (i.e. the Contractor is notified of a retroactive termination), then the Contractor shall make every effort reasonable effort to recoup monies paid to any provider and will repay TennCare in the amount collected. The Contractor shall report monthly the amount recouped by the Contractor and the amount to be repaid to TennCare. The Contractor shall submit a draft report format for TennCare review within thirty (30) days of signature of this Amendment Two. The report format will be agreed upon by the Contractor and TennCare a minimum of thirty (30) days prior to the delivery of the initial report. In addition, the Contractor shall reimburse TennCare monthly for monies owed to TennCare as a result of billing for recipients not eligible to receive services. This will be done upon the reversal of identified claims. TennCare is responsible for		

	communicating termination dates, in addition to the date of death, for any deceased members using the standard 834 transaction.		
A.2.2.3 Phases I, II, and III – Implementation dates	Phase I shall include the following edits: <u>Script Limit Edit</u> This claim limit restricts the maximum number of claims per month that certain, specified recipients can receive under the TennCare benefit. A "hard" limit restricts dispensing to the specified limit with the exception of drugs included on a shortlist developed by TennCare. TennCare shall transmit eligibility/enrollment information to the Contractor via the standard HIPAA 834 transaction as defined by the TennCare Companion Guide. The Contractor must use this information to immediately identify individuals who have no limits, have no pharmacy benefit, or are subject to limits. or whose enrollment status has changed, update the eligibility information in the Contractor's data system, and take appropriate action as outlined below. The NCPDP 1.1 formats must be used for encounter reporting sent to TennCare. <u>Tiered Co-pay Edit</u> A tiered co-pay structure shall be coded into the POS system. Initially, only two tiers may be established. A more complex structure may be required by TennCare at a later date without any additional implementation or pre-operational compensation due to the Contractor.	Phase I shall begin upon signature of Contract Amendment Two. The completion date shall be no later than May 1, 2005	Phase I Implementation: penalty will be $8,000 per week for each edit not operational by May 1, 2005. Calculation to begin on May 2, 2005.

	Step Therapy Edit PDL management identifies and promotes the use of the most cost-effective drug therapy within a therapeutic class; step therapy promotes the use of the most cost-effective therapy for a specific indication, regardless of drug class. The POS system shall be coded to edit on all drugs in the target classes which are being submitted for dispensing. There shall need to be evidence in the claims history of prior use of a drug in a more cost-effective class before the new drug can gain approval through a prior authorization. Also included in this enhancement is the establishment of prior authorization criteria that cannot be handled with system edits but shall require calls to the Contractor's call center. The Contractor shall be responsible for making recommendations to TennCare regarding the need for such criteria and for subsequent criteria and call center protocol development. To the extent these criteria are not associated with drugs in categories reviewed for the PDL, the call center rates specified in Attachment B shall apply. The Contractor shall assure that call center staff shall be available to evaluate prior authorization requests per the standards required in section A.3.5.1 and A.3.5.3 of the contract. An agreed upon set of edits/PA criteria in this category shall be implemented during Phase II. Additional edits of this type shall be implemented at TennCare's direction at any point in the		

	term of the Contract without additional implementation or pre-operational compensation due to the Contractor. While the Contractor shall recommend possible step therapy edits on Prior Authorization criteria for review by the Pharmacy Advisory Committee the State shall have final decision on method and timing of implementation. <u>Gross Amount Due (GAD) Edit</u> As defined by TennCare. <u>Drug to Gender Edit</u> Any medication which is specifically indicated for either a male or female shall reject at the point of service if the medication is prescribed for a patient of the opposite gender. <u>Maximum Dollar Amount Edit</u> All pharmacy claims over a specified dollar amount per claim shall reject at the point of service and shall require the pharmacy provider to call the First Health Services Call Center. This includes a $250 limit on compounded claims, a $10,000 limit on non-compounded, non-exception claims, a $2,500 limit on Total Parenteral Nutrition (TPN) products and a $50,000 limit on exception claims (blood factors and other identified products). <u>DEA Number Edit</u> The claims processing system shall be set to deny for all controlled substances where the DEA number used is not active in the National DEA file (NTIS) used by the Contractor. <u>Drug Dosage and Dose Optimization Edit</u>		

	The dose optimization edit shall assess the tablet strengths of a drug and assure that the most cost-effective strength is dispensed. Appropriate selection shall assist in minimizing the cost of therapy. The POS system shall be coded to limit the quantity per prescription to ensure the most cost-effective strength is dispensed. Also, where there are appropriate concerns with respect to over-utilization of medications, quantity limits shall be entered into the system. The pharmacy shall receive a hard denial for any claim that exceeds the limit. A prescriber must obtain a prior authorization in order for the claim to process through the system. <u>Drug Duplication of Therapy Edit</u> This edit automatically identifies and reports problems that involve therapeutic duplications of drugs when the submitted claim is associated with other drugs or historical claims identified for a given enrollee. An agreed upon set of edits in this category shall be implemented during Phase II. Additional edits of this type shall be implemented at TennCare's direction at any point in the term of the Contract without additional implementation or pre-operational compensation due to the Contractor. <u>OTC Drug Coverage Elimination</u> TennCare intends to eliminate OTC drug coverage for all		

	adults, with the exception of prenatal vitamins for pregnant women. OTC drugs for children and prenatal vitamins for pregnant women will only be covered to the extent that they are prescribed by a health care provider legally qualified to write prescriptions. Phase II shall include the following edits: <u>Unit of Measure Edit</u> The Unit of Measure (UOM) edit shall perform two main functions: a) check incoming claim units (i.e. gram, ml, etc) versus the units listed in FirstDatabank for that particular NDC b) verify that the unit amounts transmitted are consistent with the unit amounts in First Databank (The submitted quantity must be a multiple of the unit size shown in FirstDatabank. i.e. claim shall be reject if unit amount transmitted has been rounded, - example - units transmitted is 14, but unit amount is 13.7 in FirstDatabank) An agreed upon set of edits in this category shall be implemented during Phase II. Additional edits of this type shall be implemented at any point in the term of the Contract without additional implementation or pre-operational compensation due to the Contractor. <u>MAC/DAW</u> Requires medical justification to be provided for a Branded	Phase II shall begin upon written notification of TennCare. The completion date shall be sixty (60) days following the written notification of TennCare.	Phase II and Phase III Implementation: penalty will $3,500 per week for each edit not operational by “date to complete implementation.” Calculation to begin day after “date to complete implementation” (see Section A.1.1).

	product when a generic substitute is available. When a prescriber writes a prescription for a multi-source product and requests that the prescription be Dispensed As Written (DAW). The pharmacist uses the DAW1 edit to allow dispensing of the brand, but the claim shall only pay at the lower payment (MAC) or the pharmacist shall call the prescriber and change the prescription to an alternate agent. If the prescriber shall not change to an alternate agent, then the prescriber or prescriber's agent must call for a prior authorization. Phase III shall include the following edits: <u>Prescriber Last Name Edit</u> The claims processing system shall be set to ensure that the valid DEA number matches the correct last name of the prescriber. <u>Drug-Drug Interaction Edit</u> This edit automatically identifies and reports problems that involve use of drugs contraindicated by other drugs on current and historical claims for a given enrollee. Also, it automatically indicates and reports on the level of severity of the drug/drug interaction. <u>Drug Duration Edit</u> Duration of Therapy is performed to determine whether the current prescription exceeds the recommended maximum days supply for that drug and is based on commonly used drug and clinical data.	Phase III shall begin upon written notification of TennCare. The completion date shall be sixty (60) days following the written notification of TennCare.	

	Drug to Disease Edit This edit automatically identifies and reports problems which involve use of drugs contraindicated by inferred diagnosis codes on current and historical claims for a given enrollee. Many, if not all, of the edits listed above in Phases I to III shall be processed and resolved automatically at POS and require little or no intervention by First Health Services Call Center. It should be understood by the Contractor that lack of resolution of an automated edit shall most likely result in additional calls, leading to an override or prior authorization.		
A.2.2.6	Reversals and Adjustments. The system must provide an efficient means of reversing or adjusting claims both before and after the claim has been transmitted to the TCMIS. The result of the adjustment must be transferred to TCMIS for further processing. TennCare will make no payments to the Contractor for reversed, voided or adjusted claims. Contractor shall process all reversals requested by TennCare Fiscal Services Unit within thirty (30) days and provide confirmation to TennCare Fiscal Services Unit when that such has occurred.		$100 per transaction that has not been reversed or adjusted within thirty (30) days of written request of TennCare Fiscal Services Unit.
A.2.4.2. Encounter Reports	Post-adjudicated claims (encounters) must be reported by the Contractor on a schedule designated by TennCare. The current schedule is weekly. The NCPDP 1.1 formats must be used for encounter reporting sent to TennCare.	Report due weekly and due ten (10) business days after end of reporting week.	If the Contractor fails to produce the report, the calculation of the damages will begin on the first day following the due date of the report and will continue until receipt of the

	Failure to report post-adjudicated claims (encounters) to TennCare weekly may result in liquidated damages as provided herein.		report by TennCare. Penalty will be $5,000 per week.
A.3.1.10	The Contractor will monitor compliance, by prescribers and pharmacists, with the TennCare PDL, report that information to TennCare monthly and quarterly, and semiannually, and provide suggestions for improving PDL compliance. The Contractor shall create and forward a PDL Bonus Payment Report which shall outline the percentage of prescriptions dispensed which have adhered to the PDL during the previous six (6) month period. This Report shall be sent directly to TennCare Fiscal Services Unit within forty-five (45) days following the period but not earlier than thirty (30) days following the period.	Report to be delivered within forty-five (45) days following the period, but not earlier than thirty (30) days following the period.	Penalty will be $500 per week that report is overdue.
A.3.1.17	The Contractor shall perform supplemental rebate calculations including National Drug Code (NDC) information and invoice the manufacturers within five to thirty (5-30) days after the receipt of the quarter CMS rate file. The invoices must be approved by TennCare and contain information sufficient to minimize disputes and comply with supplemental rebate contracts with the manufacturers.		Penalty will be $1,000 per invoice per day invoice overdue.
E.4.a.(2) Breach, Partial Default	In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of: (1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State shall	Contract Performance Standard	The amount of liquidated damages assessed against the Contractor shall be at the discretion of the State, in accordance with the specific penalty provisions contained

	begin to provide the service associated with the Breach. Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor. In the event the State declares a Partial Default, the State may withhold, together with any other damages associated with the Breach, from the amounts due the Contractor the greater of: (1) amounts which would be paid the Contractor to provide the defaulted service; or (2) the cost to the State of providing the defaulted service, whether said service is provided by the State or a third party. To determine the amount the Contractor is being paid for any particular service, the Department shall be entitled to receive within five (5) days any requested material from Contractor. The State shall make the final and binding determination of said amount. The State may assess Liquidated Damages on the Contractor in accordance with the penalty provisions contained herein for any failure to perform which ultimately results in a Partial Default with said Liquidated Damages to cease when said Partial Default is effective. Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor agrees to cooperate fully with the State in the event a Partial Default is taken.		in the base Contract and this Amendment, and not exceed 10% of the maximum payments previously made by TennCare to Contractor

Timely implementation of the above cost containment measures, and assessment by TennCare of any penalties for Contractor's failure to do so, are contingent upon the following:

- TennCare staff being available to support each initiative in the form of timely review, approval and oversight
- TennCare staff being responsible for all interactions with CMS to receive program approvals
- TennCare ansuring that its MMIS contractor provides system modifications to support the implementation of the cost containment program

For all file interfaces, any changes to the file format, schedule, or media type will go through the full Change Control, testing, and be signed-off by TennCare and Contractor.

Receipt of the weekly files may be rescheduled upon agreement of both parties without damages being incurred.

ATTACHMENT B
TennCare Contract Amendment Pricing

Initiative	Sub-Initiative	Implementation Fee (1)	Pre-Operational Call Center Fee (per Week) (2)	Monthly Administrative Fee (3)	Call Center Rates (4)			
					Fee Per Non-Clinical Resolution	Grier-compliant Clinical Prior Authorizations		
						Rx Technician	Pharmacist	Physician
Administrative Edits	DEA Number Edit	79,514	N/A	-	3.55	N/A	N/A	N/A
	Prescriber Last Name Edit	145,079	N/A	-	3.55	N/A	N/A	N/A
	Drug to Gender Edit	69,086	N/A	-	N/A	N/A	15.15	44.80
	Gross Amount Due Edit	165,362	N/A	-	3.55	N/A	N/A	N/A
	Maximum Dollar Amount Edit	69,086	N/A	-	N/A	N/A	15.15	N/A
	Unit of Measure Edit	121,926	N/A	-	N/A	7.22	N/A	N/A
	MAC/DAW	95,157	11,015	-	N/A	7.22	N/A	N/A
Clinical Edits	Drug Dosage & Dose Optimization Edit	78,397	10,246	-	N/A	7.22	15.15	44.80
	Drug Duplication of Therapy Edit	229,233	55,326	-	N/A	7.22	15.15	44.80
	Drug-Drug	224,763	47,130	-	N/A	7.22	15.15	44.80

	Interaction Edit							
	Drug Duration Edit	78,397	2,049	-	N/A	7.22	15.15	44.80
	Drug-to-Disease Edit	78,397	4,098	-	N/A	7.22	15.15	44.80
	OTC Class Elimination	75,045	N/A	-	3.55	N/A	N/A	N/A
Step Therapy		215,080	45,080	-	N/A	7.22	15.15	44.80
Script Limit Edits	Hard Limit for Non-Exempts	159,231	29,870	-	3.55	N/A	N/A	N/A
Tiered Co-pay Edits		173,445	1,102	-	3.55	N/A	N/A	N/A
MAC		49,645	N/A	-	3.55	N/A	N/A	N/A
Additional Dedicated Staff (5)	1 Clinical Pharmacist based in Nashville			13,469				
	2 Provider Educator Pharmacists based in Nashville			22,358				
	1 Pharmacy Research Scientist			15,650				
	1 Data Quality Analyst based in Nashville			9,216				
	1 Systems Liaison based in Richmond			12,587				
	1 Contract Manager based in Richmond			12,619				
	1 Business Analyst based in Richmond			7,173				
	1 Reform Project Manager based 25% in Nashville, balance in Richmond			12,256				
	2 Mail Room Clerks (ongoing)			7,244				
	8 Temp Mail Room Clerks (3 months*)			28,976				
RetroDUR (Takeover from UT)		173,136	N/A	45,833				
Equipment		-	N/A	-				
Totals		**2,279,979**	**205,915**	**187,381**				

Notes:

(1) The Call Center Planning and Development deliverable is payable for each initiative upon notice from TennCare to begin implementation of the phase in which the edit resides. Other subcomponents of the implementation fee are payable upon TennCare receipt and approval of the associated deliverable. (see Attachment C)

(2) Pre-operational call center fees are payable for each initiative (and sub-initiative, as applicable) in the event that TennCare delays the "go live" date. These fees shall begin on the planned "go live" date and cease when the edit actually does "go live" (i.e.hard-edits become fully operational and call center rates become effective) or when TennCare gives notice to cancel the initiative. The "go live" date is specified in the contract as the "date to complete implementation", except as it relates to the Script Limit and Tiered Co-pays. For these groups of edits, the "go live" date shall be communicated in writing by TennCare to First Health no less than 6 weeks prior to the intended "go live" date.

(3) Monthly administrative fees are payable for each initiative (and sub-initiative, as applicable) upon First Health Services' written notice to TennCare that the initiative is operational or that additional dedicated staff are hired, as applicable. Partial months shall be prorated.

(4) PDL related prior authorizations are covered under the base contract. For the initiatives added via Amendment Two, prior authorizations will be billed on a “per resolution” basis. If multiple calls are required to resolve a given issue (e.g. issue a Prior Authorization), the Contractor will only bill for a single unit of the highest level call that took place.

(5) Any System Change Requests made by TennCare and not explicitly described in this Amendment will be billable to TennCare at a rate of $150 per hour.

* The 8 temporary mail room clerks will be added for a three month period to process returned mail associated with the reissuing of ID cards of the TennCare population if such reissuing is directed by TennCare.

ATTACHMENT C

Implementation Deliverables List

Initiative/Sub-Initiative	Deliverable	Fee
DEA Number Edit	Call Center Planning and Development	$ 79,514
Prescriber Last Name Edit	Call Center Planning and Development	$ 78,397
	System Coded to Edit on Last Name and Approved by TennCare	$ 66,682
Drug to Gender Edit	Call Center Planning and Development	$ 69,086
Gross Amount Due Edit	Call Center Planning and Development	$ 83,984
	System Coded to Edit on Gross Amount Due and Approved by TennCare	$ 81,378
Maximum Dollar Amount Edit	Call Center Planning and Development	$ 69,086
Unit of Measure Edit	Call Center Planning and Development	$ 69,086
	System Coded to Edit on Unit of Measure and Approved by TennCare	$ 52,840
MAC/DAW	Call Center Planning and Development	$ 95,157
Drug Dosage & Dose Optimization Edit	Call Center Planning and Development	$ 78,397
Drug Duplication of Therapy Edit	Call Center Planning and Development	$ 229,233
Drug to Drug Interaction Edit	Call Center Planning and Development	$ 224,763
Drug Duration Edit	Call Center Planning and Development	$ 78,397
Drug to Disease Edit	Call Center Planning and Development	$ 78,397
Step Therapy	Call Center Planning and Development	$ 215,080
OTC Class Elimination	Call Center Planning and Development	$ 37,523
	System Coded to appropriately deny OTC medications for affected recipients	$ 37,522
Script Limit Edits	Call Center Planning and Development	$ 80,632
	Requirements Defined and Documented in TennCare-Approved CSA	$ 39,300
	System Coded to Edit on Script Limit Criteria and Approved by TennCare	$ 39,300
Tiered Co-pay Edits	Call Center Planning and Development	$ 75,045
	Requirements Defined and Documented in TennCare-Approved CSA	$ 49,200
	System Coded to Edit on Tiered Copays and Approved by TennCare	$ 49,200
MAC	Call Center Planning and Development	$ 15,621
	Requirements Defined and Documented in TennCare-Approved CSA	$ 34,024
RetroDUR (Takeover from UT)	Plan Delivery	$ 98,136
	Requirements Defined and Documented in TennCare-Approved CSA	$ 25,000
	Year-one RetroDUR Plan Submitted to TennCare	$ 25,000
	DUR Board Members Recruited and Trained	$ 25,000
Total		**$2,274,021**

CONTRACT SUMMARY SHEET

RFS Number:	318.65-128	**Contract Number:**	FA-04-15757-01
State Agency:	Department of Finance and Administration	**Division:**	Bureau of TennCare

Contractor	**Contractor Identification Number**	
First Health Services Corporation	X V- C-	540849793 03

Service Description

Point of Sale (POS) Pharmacy Claims Processing and Preferred Drug List Development and Management

Contract Begin Date	**Contract End Date**
January 1, 2004	December 31, 2006

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.65	073	134	11	X on STARS		

FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)
2004	$1,453,500.00	$1,453,500.00			$2,907,000.00
2005	$2,693,550.00	$2,693,550.00			$5,387,100.00
2006	$2,294,550.00	$2,294,550.00			$4,589,100.00
2007	$1,154,900.00	$1,154,900.00			$2,309,800.00
Total:	**$7,596,500.00**	**$7,596,500.00**			**$15,193,000.00**

CFDA #	93.778

State Fiscal Contact

Name:	Dean Daniel
Address:	729 Church Street Nashville, TN
Phone:	(615) 532-1362

Procuring Agency Budget Officer Approval Signature

Check the box ONLY if the answer is YES:	
Is the Contractor a SUBRECIPIENT? (per OMB A-133)	x
Is the Contractor a VENDOR? (per OMB A-133)	
Is the Fiscal Year Funding STRICTLY LIMITED?	
Is the Contractor on STARS?	x
Is the Contractor's FORM W-9 ATTACHED?	
Is the Contractors Form W-9 Filed with Accounts?	x

COMPLETE FOR ALL AMENDMENTS (only)

	Base Contract & Prior Amendments	This Amendment ONLY
END DATE →	12/31/2006	
FY: 2004	$2,907,000.00	
FY: 2005	$4,987,500.00	$399,600.00
FY: 2006	$4,189,500.00	$399,600.00
FY: 2007	$2,109,000.00	$200,800.00
FY:		
Total:	$14,193,000.00	**$1,000,000.00**

Funding Certification

Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

PROCESSED

FA 04-15757-01

FIRST HEALTH SERVICES CORPORATION:

12/1/04

Teresa R. DiMarco, President — Date

DEPARTMENT OF FINANCE AND ADMINISTRATION, TENNCARE BUREAU

M. D. Goetz, Jr. DO — 12/17/2004

M. D. Goetz, Jr., Commissioner — Date

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr. DO — DEC 21 2004

M. D. Goetz, Jr., Commissioner — Date

COMPTROLLER OF THE TREASURY:

John G. Morgan — 12/22/04

John G. Morgan, Comptroller of the Treasury — Date

AMENDMENT #1
TO FA-04-15757-00
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
TENNCARE BUREAU
AND
FIRST HEALTH SERVICES CORPORATION

This Contract, by and between the State of Tennessee, Department of Finance and Administration, TennCare Bureau hereinafter referred to as the "State" or "TennCare" and First Health Services Corporation, hereinafter referred to as the "Contractor," is for the provision of Pharmacy Management and Preferred Drug List Services, as further defined in the "SCOPE OF SERVICES" is amended as follows:

1. Amend Section A.11 of the Contract by deleting it in its entirety and substituting the following:

A.11. TennCare Member Identification Cards

The Contractor shall provide each TennCare member with a permanent pharmacy benefit identification card by February 1, 2004. The card shall comply with all state laws and NCPDP guidelines regarding the information required on the card. The card shall also list any appropriate copays for the member and an effective date for the card. The Contractor shall provide pharmacy benefit identification cards for new TennCare members added to the TennCare eligibility file on an ongoing basis.

The Contractor shall be reimbursed for costs as acceptable and approved by TennCare and which relate to the production or replacement of the identification cards. The Contractor must invoice TennCare in writing and must delineate the actual costs incurred. TennCare has the final approval on payment of the invoice.

Mailings pursuant to this Section of the Contract shall be mailed first class unless otherwise approved or directed by the State. The direct postage cost, shall be a pass-through item and shall not include Contractor postage for any other Contractor business operations. The State shall reimburse the Contractor for actual costs.

2. Amend Section C.1. of the Contract by adding a new section C.1.1 as follows:

C.1.1. In addition to the maximum liability for professional services the State shall deem certain costs incurred by the Contractor and agreed to by the parties (including, but not limited to, specified postage) as pass-through costs for which the State shall reimburse the Contractor actual costs.

3. Amend Section C.1. by deleting it in its entirety and substituting the following:

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Fifteen Million One Hundred Ninety-Three Thousand Dollars

($15,193,000.00). The Service Rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The Service Rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor. Notwithstanding the above, the Contractor shall be reimbursed for any “pass-through” costs for which the parties have agreed.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the Service Rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

The other terms and conditions of this contract not amended hereby shall remain in full force and effect.

FIRST HEALTH SERVICES CORPORATION:

Teresa R. DiMarco, President **Date**

DEPARTMENT OF FINANCE AND ADMINISTRATION, TENNCARE BUREAU

M. D. Goetz, Jr., Commissioner **Date**

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr., Commissioner **Date**

COMPTROLLER OF THE TREASURY:

John G. Morgan, Comptroller of the Treasury **Date**

CONTRACT SUMMARY SHEET

RFS Number:	318.65-128	**Contract Number:**	FA-04-15757-00
State Agency:	Department of Finance and Administration	**Division:**	Bureau of TennCare

Contractor	**Contractor Identification Number**	
First Health Services Corporation	X V- C-	540849793 03

Service Description

Point of Sale (POS) Pharmacy Claims Processing and Preferred Drug List Development and Management

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January 1, 2004	December 31, 2006

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.65	073	134	11	X on STARS		

FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)
2004	$1,453,500.00	$1,453,500.00			$2,907,000.00
2005	$2,493,750.00	$2,493,750.00			$4,987,500.00
2006	$2,094,750.00	$2,094,750.00			$4,189,500.00
2007	$1,054,500.00	$1,054,500.00			$2,109,000.00
Total:	**$7,096,500.00**	**$7,096,500.00**			**$14,193,000.00**

CFDA # 93.778

State Fiscal Contact

Name: Dean Daniel
Address: 729 Church Street
Phone: Nashville, TN (615) 532-1362

Procuring Agency Budget Officer Approval Signature

Dean Daniel 11/17/03

Check the box ONLY if the answer is YES:	
Is the Contractor a SUBRECIPIENT? (per OMB A-133)	x
Is the Contractor a VENDOR? (per OMB A-133)	
Is the Fiscal Year Funding STRICTLY LIMITED?	
Is the Contractor on STARS?	x
Is the Contractor's FORM W-9 ATTACHED?	
Is the Contractors Form W-9 Filed with Accounts?	x

COMPLETE FOR ALL AMENDMENTS (only)

	Base Contract & Prior Amendments	This Amendment ONLY
END DATE →		
FY:		
FY:		
FY:		
FY:		
FY:		
Total:		

Funding Certification

Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

DEC 15 2003

DIRECTOR OF ACCOUNTS

IN WITNESS WHEREOF:

FIRST HEALTH SERVICES CORPORATION:

Teresa R. DiMarco, President — Date: 11-17-04

DEPARTMENT OF FINANCE AND ADMINISTRATION, TENNCARE BUREAU

M. D. Goetz, Jr., Commissioner — Date: 11/17/03

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr., Commissioner — Date: NOV 20 2003

COMPTROLLER OF THE TREASURY:

John G. Morgan, Comptroller of the Treasury — Date: 11/25/03

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
TENNCARE BUREAU
AND
FIRST HEALTH SERVICES CORPORATION

This Contract, by and between the State of Tennessee, Department of Finance and Administration, TennCare Bureau hereinafter referred to as the "State" or "TennCare" and First Health Services Corporation, hereinafter referred to as the "Contractor," is for the provision of Pharmacy Management and Preferred Drug List Services, as further defined in the "SCOPE OF SERVICES."

The Contractor is a for profit corporation.

The Contractor's address is:

4300 Cox Road

Glen Allen, VA 23060

The Contractor's place of incorporation or organization is Virginia.

A. SCOPE OF SERVICES:

A.1. Pharmacy Contract Project Director

The Contractor shall designate and maintain, subject to TennCare approval, a Project Director for this contract who has day-to-day authority to manage the total project. The Project Director shall be readily available to TennCare staff during regular working hours by working onsite within the TennCare Bureau. TennCare will provide office space for the Contractor's onsite Pharmacy Project Director The Contractor shall maintain sufficient levels of staff including supervisory and support staff with appropriate training, work experience, and expertise to perform all contract requirements on an ongoing basis. Telephone and administrative personnel shall be familiar with covered services under the TennCare pharmacy program and other member eligibility prerequisites. TennCare shall approve the Project Director and any other key positions. TennCare shall have the right to require removal from this contract of any staff found unacceptable to TennCare with cause. TennCare shall be notified within three (3) business days of key staffing changes and name changes and TennCare shall approve any such changes. The Project Director shall provide overall project coordination between the clinical and operational aspects in support to TennCare. If it becomes necessary for the Contractor to replace the Project Director, the Contractor will notify TennCare within three (3) business days of the change and TennCare shall approve any such changes.

A.2. TennCare-POS

The Contractor will provide an existing, online pharmacy point-of-sale (POS) system that can be modified to meet the needs of the TennCare-POS project. The Contractor will provide system design and modification, development, implementation and operation for the TennCare-POS Project. Modifications to the Contractor's existing system will allow it to interface with the existing pharmacy "switch" networks that connect the pharmacy providers with the Contractor's system.

The Contractor will be responsible for operating the provided system which will automate the entire pharmacy claims processing system for the complete pharmacy benefit for all TennCare enrollees. All payments for pharmacy claims will be made through the Contractor's system and electronically invoiced to TennCare weekly as a pass through.

The source of the claims will be enrolled, network pharmacy providers such as retail pharmacies, firms supplying Tennessee's nursing homes, some hospitals, mail order pharmacies and some out-of-network pharmacies (out-of-state). The majority of claims will be submitted through point-of-sale telecommunications devices, however, the Contractor will also process claims on batch electronic media for long term care pharmacy providers, the Tennessee Department of Health's TennCare pharmacy claims and non-traditional pharmacy providers as well as some paper claims submitted directly to the Contractor for processing. Paper claims may include, but not be limited to, those submitted in situations when an enrollee has to visit an out-of-state pharmacy in an emergency or in some instances, pharmacy claims from the Tennessee Department of Health. Paper claims will be submitted on universal claim forms or the current industry standard pharmacy forms (NCPDP).

Prospective Drug Utilization Review (Pro-DUR) functions provided by the Contractor through the TennCare-POS system will alert pharmacists when several defined conditions are present. These conditions will include recognizing when a prescribed drug could cause an adverse reaction when taken in combination with other drugs prescribed for the same recipient. It will also include situations when a drug may be contraindicated due to the presumed physical condition of the patient based on their drug history. The Contractor will recommend to TennCare new Pro-DUR edits designed to improve quality and reduce pharmacy program costs.

The Contractor will provide TennCare with a web-based retrospective drug utilization review (Retro-DUR) system. The Retro-DUR system will trend, on a quarterly basis, providers' prescribing habits and identify those who practice outside of their peer's norm. The Contractor's Retro-DUR system will provide TennCare with provider profiling that includes identification of prescribers who routinely prescribe non-preferred drugs. The Contractor's Retro-DUR system will identify patients who may be abusing resources through polypharmacy utilization patterns or visiting multiple providers.

The Contractor will provide Retro-DUR information to TennCare in both an aggregate and claim detail format. With such aggregate information the Contractor shall identify, at a minimum, the number of providers, the number of members, the number of pharmacies and the total dollar amount affected by varied criteria approved by TennCare and the TennCare DUR Board. The Contractor will produce reports that detail patient and prescriber trends. Those patients and providers whose utilization and prescribing patterns fall outside of TennCare-specified norms will be selected for RetroDUR program review.

The Contractor's Retro-DUR system's intervention processes shall include letter-based information to providers and a response system specific to issues identified by the Contractor or TennCare. The source for criteria and definitions will be described by TennCare and the TennCare DUR Board.

All trend measures to be analyzed and reported will be provided to the Contractor at the beginning of the quarter preceding the review period by TennCare. The Contractor will produce twenty-five hundred (2,500) case profiles per quarter. The selection process for these case profiles will be determined through discussions between the Contractor and TennCare and mutually agreed upon. The case profiles will be delivered to TennCare within one week after the end each quarter.

The Contractor will have a qualified representative attend each quarterly meeting of the TennCare DUR Board to present Pro-DUR and Retro-DUR data and findings, as well as utilization data.

The Contractor will develop and implement ongoing educational programs for the TennCare provider community designed to encourage compliance with the *Grier* Revised Consent Decree (and any modifications to the Decree), improve provider awareness of the TennCare PDL and assure PDL compliance by prescribers. These educational initiatives shall include, but not be limited to, provider letters, PDL distribution, POS messaging, training sessions, website postings of the PDL and other educational materials for prescribers. The Contractor shall prepare, for TennCare approval, provider letters containing information related to the implementation and operation of the PDL program. The Contractor shall prepare and maintain a document suitable for printing or posting to the TennCare website providing the PDL listing and all applicable drug prior authorization (PA) criteria including step-therapy algorithms. The Contractor will conduct four (4) training sessions in east, middle and west Tennessee related to the TennCare PDL program each calendar year during the life of this contract. The Contractor will distribute all Prior Authorization Call Center toll-free telephone and facsimile numbers, as well as the appropriate mailing address for prior authorization requests at all provider training sessions and provider education programs. The *Grier* Revised Consent Decree may be found on the TennCare webpage; http://www.state.tn.us/tenncare/phrgrier.htm .

The Contractor will manage the PDL in an ongoing manner, assuring new drugs or new supplemental rebate offers are managed appropriately. The Contractor will assure that the PDL decision-making process produces a list of covered drugs that are cost-effective while not overriding sound clinical judgment.

The Contractor will identify for TennCare opportunities for savings, therapeutic alternative utilization, competition to drive rebate bidding and which therapeutic categories should be avoided in association with the TennCare PDL. The Contractor will continue the supplemental rebate process with a pharmaceutical manufacturer kick-off meeting to explain the process and establish schedules for supplemental rebate negotiations. The Contractor will negotiate supplemental rebates through an open competition process within specific drug classes, thereby encouraging maximum participation among manufacturers.

The Contractor will process, invoice and collect supplemental rebates through the Contractor's rebate administration systems. The Contractor's system must be capable of supplemental rebate invoicing, payment tracking and reconciliation and dispute resolution for disputes related to supplemental rebate unit issues and utilization.

The Contractor will provide TennCare with utilization management reporting. As clinical programs are implemented, the Contractor's clinical staff will define regular reports designed to gauge the effectiveness of each initiative, including movement of market share within given therapeutic categories of the TennCare PDL. The Contractor's utilization management reporting package will be customizable to meet TennCare program analysis needs. The Contractor's utilization management reporting will contain flexible ad hoc reporting through the Contractor's web-based, Decision Support System (DSS). The criteria and format for utilization management reporting will be mutually agreed upon by TennCare and the Contractor.

A.2.1. TennCare-POS Design, Development and Implementation (DDI)

During DDI, the Contractor will implement the systems required to process all TennCare pharmacy claims and all other services described herein. The Contractor will work with TennCare to ensure that the TennCare-POS, satisfies the functional and informational requirements of Tennessee's TennCare pharmacy program. The system must be thoroughly tested prior to implementation. The Contractor will assist TennCare in the analysis and testing of the integration of these systems. Throughout the life of the contract, the Contractor will be responsible for updates to TennCare-POS system documentation detailed below.

DDI shall consist of the phases detailed in the following sections, and the Contractor shall complete all tasks associated with each phase within twenty-four (24) days prior to the start date of this Contract. All tasks shall be completed prior to implementation on January 1, 2004 but the State will not impose specific time frames for the completion of each individual task. Contractor shall be ready with all systems to go live January 1, 2004.

A.2.1.1. Project Initiation and Requirements Definition Phase. TennCare will conduct a project kick-off meeting. All key Contractor project staff will attend. TennCare project staff will provide access and orientation to the TennCare Pharmacy Program and system documentation. TennCare technical staff will provide an overview of the Tennessee TCMIS emphasizing pharmacy claims processing and adjudication, reference files, and payment processes. During this phase the Contractor will develop the following documentation:

a. Functional and Informational Requirements (FIR) Document. This document will include
detailed requirements for both internal and external interfaces and all TennCare-POS functionality required by this RFP and/or contained in the Contractor's proposal.

b. Data Dictionary. For each data field this will indicate content, size, values, structure, edit criteria and purpose.

c. Data mapping. This will consist of a cross-reference map of required TCMIS data and TennCare-POS data elements and data structures. A separate data structure map will be required for each transaction and interface. A data conversion plan, which includes both automated and manual activities, will be provided for each data structure map. TennCare will make any necessary data formats available to the Contractor.

Additionally, the Contractor shall recommend design modifications to the Tennessee TCMIS. Performing any maintenance and design enhancements to TCMIS will be the decision and responsibility of TennCare.

A.2.1.2. System Analysis/General Design Phase. After approval of the documentation required in the Project Initiation and Requirements Definition Phase, the Contractor will develop the General System Design Document. The General System Design Document will include the following information:

a. An Operational Impact Analysis that details the procedures and infrastructure required to enable TCMIS, the Contractor's system, and the "switch" systems used by pharmacy providers to work effectively together.

b. A Detailed Conversion Plan that details plans for conversion of twelve (12) months of TCMIS and the previous contractor/processor's claims history, provider, recipient, preferred drug list, prior authorization, lock-in and reference data.

c. A Software Release Plan for implementation into production and throughout the life of the project. This document will explain procedures for coordinating system changes that will have an operational or information impact on TennCare-POS operations. It will detail how software releases for TennCare-POS and/or TCMIS are tested and coordinated. The plan will include both initial implementation of the TennCare-POS system and coordination of software releases between TCMIS and TennCare-POS.

A.2.1.3. Technical Design Phase. During this phase, detailed specifications will be developed for conversion and for the interface(s) between the TCMIS and the Contractor's system.

a. The Contractor shall develop detailed plans that address back-up and recovery, information security and system testing; and, the System Interface Design Overview Document (this document will be completed after the Contractor has conducted a review of all previous design documents). These will then be consolidated into the System Interface Design Overview.

b. In addition to the System Interface Design Overview, the Contractor will provide the following system plan documents:

i. Unit Test Plan to include test data, testing process, and expected results.

ii. Back-up and Recovery Plan to include processes for daily backup and recovery and the final disaster recovery plan.

iii. Information Security Plan to include how the Contractor will maintain confidentiality of TennCare data. This document will include a comprehensive Risk Analysis.

iv. System, Integration, and Operability Test Plan.

A.2.1.4. Development Phase. This phase includes activities that will lead to the implementation of the TennCare-POS system. The Contractor will develop interface and conversion programs that include unit tests and system documentation. The Contractor must develop manual data entry screens where required. Testing will be performed and programs will be documented. The Contractor will perform testing activities that will include the following:

a. TennCare-POS system test to include a description of the test procedure, expected results, and actual results.

b. Integration testing will test external system impacts including provider POS systems, downstream TCMIS applications, and all interfaces. It will include a description of the test procedure, expected results, and actual results.

c. Operability testing will include volume and efficiency to ensure that the system is able to process the volume of TennCare pharmacy claims. It will include a description of the test procedure, expected results, and actual results.

A.2.1.5. Implementation/Operations Phase. During this phase the Contractor and TennCare will assess the operational readiness of all required system components including TCMIS, the TennCare-POS, and required communications links with the pharmacy "switch" providers. This will result in the establishment of the operational production environment in which all TennCare pharmacy claims will be accurately and reliably processed, adjudicated and paid.

a. The Contractor will develop and prepare Operations documentation of all procedures of the Contractor's performance. This will include, but may not be limited to: automated operations, data entry operations, Help Desk operations, Prior authorization Call Center and prior authorization operations/interfaces.

b. With the approval of TennCare, the Contractor will develop production and report distribution schedules.

c. The Contractor will update the operations training plan; produce, for TennCare approval, the training materials for TennCare staff, pharmacy providers, and other identified stakeholders; schedule training; and conduct training.

d. The Contractor and TennCare will prepare a final conversion plan and perform final conversion activities. This will include running conversion programs; performing manual functions; performing quality control; reporting on outcomes; and converting files in preparation for system operation.

A.2.2. TennCare-POS Functional Requirements

A.2.2.1. Claim Adjudication Services - General Requirements. This section defines claim adjudication requirements for all TennCare pharmacy claims regardless of source and including electronic batch, paper and POS claims. The timing of the adjudication will differentiate POS claims from claims submitted in batch or on paper, however, all claims must be adjudicated through a common set of processing modules. All claims adjudicated as payable must be for eligible members to enrolled or appropriate providers for approved services and in accordance with the payment rules and other policies of TennCare. All adjudicated and paid claims will be transferred weekly to the TennCare TCMIS by the Contractor. The Contractor will distribute and mail TennCare outputs (hard copy and electronic) as directed by the TennCare Bureau including but not limited to provider checks and remittance advices, returned claims, notices, provider bulletins, provider manuals and special mailings. The Contractor shall mail checks and remittance advices to pharmacy providers each week on Fridays for all claims submitted through the POS online pharmacy claims processing system. The most cost-efficient first class rate includes but is not limited to zip code, sort, carrier and route sort, etc. If the Contractor chooses not to use the most cost-efficient method of mailings without the TennCare Bureau's approval, the difference in cost shall be the responsibility of the Contractor. Mailing costs incurred by the Contractor will be treated as pass-through costs. Such costs will be billed on a monthly basis to the TennCare Bureau in addition to regular invoices and must include substantiating documentation. No overhead, administrative or other fee shall be added to such pass-through costs. Each batch must have its own reconciliation and money remits. The Contractor will be responsible for system messages and notice of claims being adjudicated payable, denied or suspended.

a. Cash flow – For checks to be issued on Friday, the Contractor must deliver the following two files to the State, in an electronic media suitable to the State, by Thursday of each week:

i. all transactions (claims, financial adjustment, etc.) that comprise the payments to be issued for Friday of that week;

ii. all payments (check register) to be made on Friday of that week.

The file described in i. above, must contain all transactions that make up the payments in the file described in number ii. above.

b. The State reserves the right to review the files prior to issuing payment and to hold or adjust any payment that is not satisfactory to the State. The State also reserves the right to withhold amounts owed to the State by any provider for which the Contractor submits a payment request. The Contractor is encouraged to offer automatic deposit to its providers. The Contractor is responsible for providing remittance advices to providers. Remittance advices will be included in payments by the Contractor to providers. The Contractor is responsible for ensuring that

any payments requested are accurate and in compliance with the terms of this contract, agreements between the State or Contractor and providers, and state and federal laws and regulations.

c. The Contractor shall have in place, a POS claims processing system capable of accepting and processing claims submitted electronically. To the extent that the Contractor compensates providers on a fee for service or other basis requiring the submission of claims as a condition to payment, the Contractor shall electronically process, as described herein, the provider's claims for covered benefits provided to members consistent with applicable TennCare policies and procedures and the terms of this Agreement. The Contractor shall mail checks and remittance advices to pharmacy providers on Friday of each week for all claims submitted through the POS online pharmacy claims processing system and for all batch and paper claims. The Contractor shall pay within twenty (20) calendar days of receipt ninety- five percent (95%) of all clean claims submitted by network and non-network pharmacy providers through POS, batch electronic and paper claims submission. The term "pay" means that the Contractor shall either send the provider cash or cash equivalent in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by that provider to the Contractor. Thereafter, the Contractor shall pay the remaining five percent (5%) of clean claims within ten (10) calendar days. The Contractor must pay the claim or advise the provider that a submitted claim is: (1) a "denied claim" (specifying all reasons for denial); or, (2) a claim that cannot be denied or allowed due to insufficient information and/or documentation (specifying in detail all information and/or documentation that is needed from the provider in order to allow or deny the claim). Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing. The Contractor will develop, maintain and distribute to pharmacy providers a pharmacy procedure and billing manual. These manuals will provide instructions to providers in the process by which the provider receives payment, in order to diminish the potential for incorrect billing and the need for adjustments or recoupments.

d. The Contractor will be responsible for processing all TennCare pharmacy claims through a POS system using the specified, current NCPDP format. Pharmacy claims will be priced and adjudicated in an online, real time POS system that results in a claim pay status of pay, suspend, or deny. The pharmacy can initiate a reversal (void) of a submitted claim. The telecommunications system supporting the POS function must be available for claims submissions by pharmacies 24 hours a day, 7 days a week (except for scheduled and approved downtime). TennCare providers are responsible for purchasing POS hardware, software and all telecommunications linkages. POS will be required of all pharmacy providers. Long term care pharmacy providers and the Tennessee Department of Health may submit batch claims as described herein.

e. The Contractor must have a procedure to, on a daily basis, maintain and update enrollee profiles with information including, but not limited to, eligibility, prescriptions submitted for adjudication to TennCare, other prescriptions, over-the-counter medications, diagnosis codes, etc.

f. The Contractor must also process and separately invoice all pharmacy claims associated with an interagency agreement between TennCare

and the Department of Children's Services (DCS) for the provision of pharmacy services to select children under DCS care.

A.2.2.2. Claims Receipt and Management

a. The Contractor will receive batch electronic, paper and point of sale (POS) claims. The Contractor must apply a unique identification number to each claim and any supporting documentation regardless of submission format. The identification number will be used to recognize the claim for research or audit purposes. Control totals will be utilized to ensure that all claims have been processed to completion. Appropriate safeguards must be in place to protect the confidentiality of client information.

b. The Contractor must establish a mail room that will receive paper and batch electronic claims. The Contractor must microfilm or otherwise image all payment requests, payments, and their related documents, adjustments, voids, prior authorizations and other documents. The microfilm/image will be the permanent record of the claim.

c. The Contractor must identify and deny claims that contain invalid provider numbers. This will include cases where the number is missing, the check digit fails, or the provider number does not identify an entity to receive a remittance advice. Claims that contain these errors must be returned to the originating provider. Pharmacy Providers must submit claims and be identified by their individual and specific NCPDP Provider Numbers (National Association of Boards of Pharmacy - NABP numbers). Prescribers must be identified on all pharmacy claims by their specific Drug Enforcement Agency (DEA) numbers, TennCare provider numbers or any other identifying number as required by TennCare or HIPAA.

d. The Contractor must identify and deny claims (unless specifically instructed differently by TennCare) that contain National Drug Code (NDC) numbers for which drug rebates under the OBRA 1990 (and subsequent amendments of OBRA 1993) or any other negotiated rebate agreement are not available, including non-covered drug codes, DESI, LTE and IRS drug codes and any terminated or obsolete drug codes.

e. The Contractor will assist TennCare in generating Medicaid quarterly drug rebate invoices by providing the designated TennCare staff monthly encounter data files that contain the specific information and in the specified format required by TennCare. These monthly encounter data files will be provided to TennCare no later than the fifteenth (15^{th}) day of the following month.

f. The Contractor must provide to the agency or business of the state's choosing, in a format described by TennCare, any and all appropriate pharmacy level claims data needed to resolve or avoid any Medicaid or supplemental drug rebate disputes. This pharmacy level claims data will be provided within fifteen (15) business days of the request by TennCare.

g. When claim resolution is being managed by TennCare staff in accordance with TennCare guidelines or held by the Contractor under TennCare written directive, these claims will not be covered by the following timeliness requirements:

i. Batch Electronic Media (EMC) Claims - The Contractor must receive claims in electronic format, separate tape from diskette,

convert diskette to tape, schedule tapes for immediate processing and return media to submitting providers within seventy-two (72) hours. The Contractor will assign identification control numbers to all batch claims within twenty-four (24) hours of receipt. The Contractor will maintain electronic backup of batch claims for the duration of the contract. If TennCare requests copies of batch electronic claims, these must be provided within twenty-four (24) hours of request. Electronic batch claims will be submitted through a sequential terminal, or similar method that will allow batch and POS claims to be adjudicated through the same processing logic.

ii. POS Claims - The Contractor will process POS claims within five (5) seconds. This is the time from when the claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor and will include all procedures required to complete claim adjudication.

iii. Paper Claims - Paper claims may include, but not be limited to, those submitted in situations when an enrollee has to visit an out-of-state pharmacy in an emergency or paper claims from any of the Tennessee Department of Health clinics. Paper claims will be submitted on universal claim forms. The Contractor will process and adjudicate these universal, paper claims within twenty (20) days of receipt. The Contractor will add all pertinent drug information data to the TennCare-POS system and DUR system immediately upon processing the claim.

h. The Contractor will provide TennCare with TennCare-POS statistics of transactions between the "switches" and the Contractor and statistics of any and all downtime associated with the Contractor's pharmacy claims processing system. Transaction reports will include: volume, longest response time and average response time. Statistics will be provided to TennCare within ten (10) business days following the end of each calendar month.

A.2.2.3. Data Validation Edits and Audits. The system must screen all claims and apply all TennCare-approved and required data validation procedures and edits. Consistency controls must be in place to ensure that dates, types, and number of services are reasonable and comply with TennCare policy.

The Contractor will immediately notify TennCare of any and all claims that have been erroneously processed, and initiate appropriate action to correct the errors (e.g., adjustments, recoveries, etc.). Incorrect claims include, but are not limited to, claims paid for ineligible members, claims paid to a terminated provider, claims paid for duplicate services, claims paid for a non-covered service, claims paid at an incorrect rate. The Contractor will follow-up such notification to TennCare by letter for any system errors that resulted in provider overpayment or other incorrect payment.

The Contractor's system must be capable of adding, changing, or removing claim adjudication processing rules to accommodate TennCare-required changes to the pharmacy program. The system must perform the following validation edits and audits:

a. Prior authorization - The system must determine whether a prescribed drug requires prior authorization, and if so, whether approval was granted prior to dispensing the prescribed drug and reimbursement to the provider.

b. Valid Dates of Service - The system must ensure that dates of services are valid dates, are no older than twelve (12) months from the date of the prescription (unless approved by TennCare) and are not in the future.

c. Duplicate Claims - The system must automatically inform the provider that the current claim is an exact or possible duplicate and deny that claim as appropriate.

d. Prescription Validity - The system must ensure that the time period for a prescription has not expired and that the number of valid refills has not been exceeded.

e. Covered Drugs - The system must verify that a drug code (NDC) is valid and the drug is eligible for payment under the TennCare pharmacy program and eligible for Medicaid drug rebates and any supplemental rebates, unless otherwise directed by TennCare.

f. Compounded Drugs - The system must capture, edit, and adjudicate pharmacy claims as necessary to support TennCare compounded drug prescription coding policy.

g. Provider Validation - The system must approve for payment only those claims received from providers eligible to provide pharmacy services and for prescriptions from TennCare and non-TennCare providers authorized to prescribe pharmaceuticals, as required by TennCare.

h. Recipient Validation - The system must approve for payment only those claims for members eligible to receive pharmacy services at the time the service was rendered.

i. Quantity of Service - The system must validate claims to ensure that the quantity of services is consistent with TennCare policy (i.e., verify that drug specific minimum and maximum quantity limitations, as well as days supply and number of prescriptions per month limitations, if imposed, are followed as described by TennCare).

j. Rejected Claims - The system must determine whether a claim is acceptable for adjudication and reject claims that are not.

k. Third Party Liability/Coordination of Benefits – When directed by TennCare, the system must validate claims to determine whether there is a liable third party, including Medicare, that must be billed prior to TennCare. The system must be able to process claims where there may be more than one third party that is liable. Additionally, the system must be able to override this edit, even at the POS level, if, under TennCare rules and policy, it is appropriate to do so. The system must also support any efforts by the State of Tennessee, TennCare or another contractor to collect third party liability or perform cost-avoidance, at the point-of-sale, related to coordination of benefits. Pharmacy providers must be educated by the Contractor regarding proper billing practices and carrier codes associated with NCPDP version 5.1. The Contractor and the Contractor's POS system must strictly adhere to state and federal laws and regulations and TennCare policy regarding coordination of benefits and third party liability. TennCare is to be the payer of last resort.

l. Drugs Covered by Medicare - The system must maintain an indicator that a drug is covered by Medicare. When processing a claim for a recipient with Medicare coverage, the system should apply this information to TennCare-defined claim adjudication logic. Drugs which are prescribed for Medicare/TennCare members (dual eligibility) and are

covered by Medicare must be denied, when appropriate, and the pharmacy provider instructed through the POS system to bill Medicare.

m. Lock-in - The system must have the capability to impose pharmacy benefits restrictions that apply to a given recipient. This includes, but is not limited to, lock-in conditions.

n. Managed Care Organizations - The system must reject claims that should rightly be processed and paid by a member's MCO for any and all physical health treatments (when that MCO is financially responsible for those claims).

o. Early Refills – The systems must be able to recognize when an enrollee attempts to refill a prescription (be it the original prescription or a new prescription for the same drug) and require that seventy-five percent of the original days supply has passed since the original filling. Overrides at the pharmacy level must be permitted by the Contractor's Help Desk, but reports should identify monthly, the enrollee and the pharmacy provider where such overrides occur.

A.2.2.4. Pharmacy Claim Processing and Payments. The system must process claims in accordance with existing TennCare policy and rules and Tennessee regulations for dispensing fees.

a. All payments for pharmacy claims will be made through the Contractor's system and electronically invoiced to TennCare weekly. A pharmacy claim is a request for payment for a specific drug, typically at the NDC code level. An adjudicated pharmacy claim is one that has been processed to either a Payable or Denied status. An adjudicated claim also includes a claim that has been previously rejected and resubmitted by the provider and is, after the subsequent submission, deemed either Payable or Denied.

b. The pricing of claims is driven by the pricing methodologies described by TennCare rules and policies. The system must compare the calculated allowed (i.e., quantity multiplied by price plus the dispensing fee) to the billing charge and authorize payment of the lesser of the two. Most generic drugs will be assigned MAC (maximum allowable cost) prices by the federal government or by TennCare. The Contractor's system must allow for such MAC price changes, as well as any other price adjustments, to be made online, real time by the TennCare Pharmacy Director or his/her appropriate staff on the day requested. NCPDP overrides at the POS level must be available to the dispensing pharmacist in the event a DAW (dispense as written) override is necessary and allowed or required by TennCare policy.

c. The system must recognize all applicable copays or coinsurance and deduct that amount from the payment made to the pharmacy provider. The Contractor is required to report copay, coinsurance and deductible information to TennCare as required by TennCare and the TennCare manager of the TCMIS.

d. For the purposes of this Contract, an adjudicated claim will not include a point-of-sale transaction that was canceled by the sender or a claim that was rejected before it could be fully adjudicated.

e. The Contractor shall be responsible for the preparation of any applicable tax information for service provider payments and the federal government (i.e. form 1099).

f. The Contractor must also process and separately invoice all pharmacy claims associated with an interagency agreement between TennCare and the Department of Children's Services (DCS) for the provision of pharmacy services to select children under DCS care. The single pharmacy provider under contract to DCS to provide these pharmacy services will bill the Contractor, through the TennCare-POS system once monthly. These claims will be paid according to the reimbursement methodology outlined in the contract between the pharmacy provider and DCS (attached as Section 7.6 of this RFP).

A.2.2.5. Claims Processing Damages

a. A grace period of two (2) days is permitted during the implementation phase, beginning with the first day of operations, during which time the State will not assess damages for failure to meet the specified performance levels, provided that the Contractor is making a good faith effort to comply with all performance levels.

b. The Contractor will be liable for the actual amount of all Contractor caused overpayments, duplicate payments or payments that should have been denied. Such liabilities will be withheld from Contractor payments until all such damages are satisfied.

c. The Contractor will be liable for the actual amount of overpayment or duplicate payment for which full recovery from the provider cannot be made, using all reasonable procedures, as determined by the State.

d. Two thousand dollars ($2,000.00) may be assessed for the first month of any failure to meet timeliness and accuracy requirements as described in Sections A.2.2.2.e., A.2.2.2.f., A.2.2.2.g.i., A.2.2.2.g.ii., A.2.2.2.g.iii., and A.2.2.2.h. above. The two thousand dollar assessment will apply to each violation of these requirements. Four thousand dollars ($4,000.00) will be assessed for each violation of the requirements in consecutive subsequent months. For example, failure to meet two of the above requirements could result in an assessment of damages of four thousand dollars ($4,000.00) and if repeated in the following month, the assessment could be an additional eight thousand dollars ($8,000.00).

A.2.2.6. Reversals and Adjustments. The system must provide an efficient means of reversing or adjusting claims both before and after the claim has been transmitted to the TCMIS. The result of the adjustment must be transferred to TCMIS for further processing. TennCare will make no payments to the Contractor for reversed, voided or adjusted claims.

A.2.2.7. State/Federal Policy Compliance. The system must fully support and comply with all applicable state and federal policies, laws and regulations with regard to standardization and verification of client eligibility, editing for pharmacy claims and confidentiality of patient records including all of the requirements of HIPAA. The TennCare Point-of-Sale system (TennCare-POS) must comply with all federal requirements for ECM systems.

A.2.2.8. Multiple Programs. The Contractor's system must be able to track pharmacy claims separately for different types of TennCare pharmacy providers and specific subsets of TennCare enrollees, as described by TennCare.

A.2.2.9. Pro-DUR. The TennCare-POS Contractor will furnish a fully automated Pro-DUR system that meets all applicable state and federal requirements including those identified in the OBRA 1990 and OBRA 1993. The Pro-DUR function must meet minimum federal DUR regulations as well as the additional specifications in this

section and be flexible to accommodate any future edit changes required by TennCare. The Contractor must prepare all CMS-required annual DUR reports.

The Contractor's system will provide Pro-DUR services which will apply TennCare-approved edits to all claims. The edits will determine problems with a prescription and will validate medical appropriateness of the prescribed drug by comparing the circumstances surrounding the request with established pharmacy-related therapeutic criteria.

The Contractor's POS system must be capable of applying results of Pro-DUR processing in the claim adjudication process. The Contractor may use an existing DUR package but must be prepared to make any modifications required by the TennCare Bureau. The Contractor will work with TennCare in setting the disposition of Pro-DUR edits which may vary by type of submission (e.g., POS vs. batch).

The Contractor's system will include the following minimum prospective drug utilization review (Pro-DUR) features.

a. Potential Drug Problems Identification. The Contractor's system will accept and use only TennCare-approved criteria and will perform automated Pro-DUR functions that include, but are not limited to:

   i. Automatically identify and report problems that involve potential drug over-utilization.

   ii. Automatically identify and report problems that involve therapeutic duplication of drugs when the submitted claim is associated with other drugs or historical claims identified for a given enrollee.

   iii. Automatically identify and report problems which involve use of drugs contraindicated by presumed diagnosis codes on historical claims for a given enrollee.

   iv. Automatically identify and report problems that involve use of drugs contraindicated by other drugs on current or historical claims for a given enrollee (drug/drug interactions).

   v. Automatically indicate and report the level of severity of drug/drug interactions.

   vi. Automatically identify and report drugs that are contraindicated when the enrollee could be pregnant (female patients of childbearing age).

   vii. Automatically identify and report potentially incorrect drug dosages.

   viii. Automatically identify and report potentially incorrect drug treatments.

   ix. Automatically indicate and report potential drug abuse and/or misuse based on a given members prior use of the same or related drugs.

   x. Automatically identify early refill conditions and provide, at the drug code level, the ability to deny these claims.

b. POS Provider Cancel or Override Response to Pro-DUR Messages. The Contractor's system must, prior to final submission of POS pharmacy claims, automatically generate Pro-DUR messages in a

manner that will enable a pharmacy provider to cancel submission of the claim or to submit it if it is a message that can be overridden.

c. POS Provider Comment on Pro-DUR Messages. The Contractor's system must allow providers to enter comments in response to Pro-DUR messages. The system must capture and store all NCPDP standard DUR conflict, intervention, and outcome messages for reporting to TennCare.

d. Flexible Parameters for Generation of Pro-DUR Messages. The Contractor's system must have the ability to transmit new or revised Pro-DUR messages and to define the Pro-DUR criteria that activate these messages. The system will maintain a TennCare-controlled set of parameters to the situations for which a particular online Pro-DUR message will be generated. The system must provide and permit the use of all general system parameters regarding data access, support and maintenance. Variables subject to TennCare definition and control include, but are not limited to: NDC code (including multiple NDC codes subject to potential drug/drug interaction); date of service; drug strength; drug quantity; daily supply; and Generic Drug Code or GCN.

e. Pro-DUR Enrollee Profile Records. The Contractor's system will provide and maintain enrollee profiles for Pro-DUR processing of submitted claims. Building recipient profiles will be based on inferred and actual diagnoses from pharmacy claims and other data available.

f. Disease/Drug Therapy Issues Screening. The Pro-DUR system must have the capability to screen for drug therapy concerns by specific drugs relative to high-risk disease, to include but not limited to: cardiovascular disease; cerebrovascular disease; central nervous system disease; renal disease; endocrine disease; gastrointestinal disease; psychiatric disease; and respiratory disease.

g. Patient Counseling Support. The Contractor's system will present Pro-DUR results to pharmacy providers in a format that will support their ability to advise and counsel members appropriately.

h. Consulting Pharmacist Services. The Contractor will provide the services of a consulting Pharmacist to advise TennCare, its DUR Board, the TennCare Pharmacy Advisory Committee and agents on pharmacy drug utilization review (DUR) issues, including but not limited to the DUR criteria to be used in the Pro-DUR program. The consulting pharmacist must be prepared to attend all DUR and TennCare Pharmacy Advisory Committee meetings, at the request of TennCare.

i. Help Desk for System Support. The Contractor will maintain toll-free telephone access to support system operations. This Help Desk will be available twenty-four (24) hours a day, seven days a week to respond to questions and problems from providers regarding system operations and claims inquiries. The Contractor must supply all required information systems, telecommunications, and personnel to perform these operations.

j. Manual Pricing. The Contractor will provide the services of Registered (licensed) Pharmacists for calculating the reimbursement pricing, based on guidelines provided by TennCare, for certain prior authorized drugs (i.e. compounded prescriptions). The price thus established for the specific prescription, rather than the price set in the system, must be used to adjudicate claims for the patient.

A.2.3. TennCare-POS Technical Requirements

A.2.3.1. TCMIS Interface. Operation of the TennCare-POS requires ongoing interfaces with TCMIS and with the pharmacy "switch" providers. The Contractor must coordinate with TennCare to design an effective interface between TCMIS and the Contractor's system for pharmacy claims processing, Pro-DUR and TennCare's Pharmacy Unit.

a. In order to ensure the security and confidentiality of all transmitted files, the Contractor must have a system that establishes a dedicated communication line connecting TCMIS to the Contractor's processing site. The cost of this communication line is to be borne solely by the Contractor. This dedicated communication line must meet specifications of the TennCare Bureau, OIR and the State of Tennessee.

   i. All circuits, circuit terminations and supported network options are to be coordinated through Ken Barker, Director of Information Services, TennCare, 729 Church Street, Nashville, Tennessee 37247-6501.

   ii. Contractor must contact TennCare's Director of Information Services before placing all line orders.

   iii. Contractor is responsible for providing compatible mode table definitions and NCP configurations for all non-standard system gens.

   iv. Contractor is responsible for supplying both host and remote modems for all non-State initiated circuits.

   v. Dial-up access into production regions is prohibited.

b. After the pre-implementation conversion process, transaction data that changes baseline TCMIS files will be transferred to the Contractor's system on a daily basis unless TennCare approves a less frequent schedule. The system design will be finalized during the DDI phase and, at a minimum, will result in the daily update of the TennCare-POS system with the most current information from TCMIS. This may include, but not be limited to, Recipient Eligibility, Prior authorization information and Provider and Reference information.

c. The format of the data exchange will be determined during DDI and will resolve any incompatible data format issues that may exist between the Contractor's system and TCMIS. TCMIS may be modified to expand certain fields, however, the Contractor must develop the interface between the two systems and the planned TCMIS replacement system that should become active on October 1, 2003. This assumes no significant changes to TCMIS file structures will be required. After the initial TennCare-POS implementation, TCMIS may be enhanced to improve data compatibility between the POS environment and TCMIS.

d. Daily batch files will be transmitted both from TCMIS to the Contractor and from the Contractor to TCMIS. The transmission from TCMIS may contain, but not be limited to, recipient and provider eligibility records, claim history, prior authorization information and drug formulary information (Procedure Formulary File or PFF). The recipient identification number is a nine (9) byte record and is the key indicator for the eligibility record. This number is constant for a given recipient. The

Contractor to TCMIS transmission will contain records of processed, adjudicated and paid claims.

e. The Contractor is required to notify TennCare, in a manner described by TennCare; each time a file is received from TennCare in order to verify transmission and receipt of the files.

A.2.3.2. POS Network Interfaces

a. At initial system implementation, data transmissions between the TennCare-POS and the Pharmacy Providers will be in National Council on Prescription Drug Programs' (NCPDP) most current version. As updates to the NCPDP format become available, the TennCare-POS Contractor will maintain compatibility both with Providers using the updated version and those using the superseded versions. Maintenance of compatibility for each superceded version shall continue until the updated version becomes generally available.

b. The Contractor will support pharmacy providers in their interaction with the TennCare-POS and coordinate with network vendors to ensure smooth operation of the TennCare-POS with the commercial pharmacy POS environment. There are approximately eighteen hundred (1,800) pharmacy providers in the TennCare Participating Pharmacy Provider network. The Contractor must establish testing procedures and certify provider practice management systems (i.e., "switches") as compatible and ready to interface with the TennCare-POS. The Contractor is not required to supply hardware or software to pharmacy providers.

c. The TennCare-POS Contractor may not use its position as the TennCare pharmacy claims processing agent to create barriers to VANs, providers, or pharmacy practice management vendors who wish to participate in the TennCare-POS. Connection or access charges levied by the TennCare-POS Contractor to VANs or other switching companies may not be used to provide market advantages to any network over another.

d. Federal regulations require TennCare to maintain appropriate controls over POS eligibility Contractors who perform both switching services and billing services. Switch and billing agent functions, if provided by the same company, must be maintained as separate and distinct operations. If the Contractor serving as the TennCare-POS Contractor also provides services as the providers' agent, an organizational "firewall" must be in place to separate these functions.

A.2.3.3. Batch Claim Submission Format and HIPAA Compliance

a. It is TennCare's intention to allow submitters of batch electronic claims to continue to use this format while they convert to the standard claim format promulgated by the Secretary of Human Services as specified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Conversion to the HIPAA standard is expected to occur during the life of this contract and the Contractor will accommodate this conversion at no additional charge.

b. TennCare expects that NCPDP standards will be the basis for HIPAA standards for retail pharmacy claims and that the X12 837 claim will become the standard for batch claim submission for institutional and professional claims. It is TennCare's intention to allow batch submittal of electronic claims to continue in its current format for long term care and other non-traditional pharmacy providers during the time it takes them to

convert to the HIPAA standard for pharmacy claims submission. The schedule for this migration will be coordinated with the TennCare-POS implementation.

c. The Contractor will coordinate with TennCare to ensure that the electronic formats used for the TennCare-POS conform to regulations as they exist during the course of the contract.

A.2.3.4. TennCare-POS Interface Software. The Contractor must provide software to allow TennCare to test the Contractor's system through the TennCare network. During the DDI TennCare will test submission and receipt of NCPDP point-of-sale transactions. After implementation, and during the life of the contract, TennCare will test and audit performance of the system.

A.2.3.5. TennCare-POS System Availability Requirements. The Contractor must ensure that the average system response time is no greater than five (5) seconds for all transactions a minimum of ninety-eight percent (98%) of the time seven (7) days per week twenty-four (24) hours per day. Cumulative system downtime must not exceed two (2) hours during any continuous five (5) day period.

The TennCare-POS system must be available twenty-four (24) hours per day, seven (7) days per week, for provider inquiry or billing purposes. Such availability must include all normal forms of entry. The Contractor may have scheduled maintenance downtime as approved by the State.

A.2.3.6. System Maintenance and Modification Deadlines and Damages. System maintenance problems must be corrected within five (5) business days or by a correction date approved by the State. Five hundred dollars ($500.00) liquidated damages per work day or any part thereof shall be assessed for a maintenance problem not corrected within five (5) business days or by correction date approved by the State. Five hundred dollars ($500.00) liquidated damages per work day or any part thereof will be assessed for a modification not completed by the date approved by the State. These payments will be in addition to payment for any actual damages due to incorrect payment processing, including but not limited to damages based on loss of productivity of TennCare staff because of staff time required to respond to inquiries from auditors, users, members, advocates, legislators and in meetings with Contractor staff to rectify problems.

A.2.3.7. System Security, The Contractor will apply recognized industry standards governing security of State and Federal Automated Data Processing systems and information processing. At a minimum, the State requires the Contractor to conduct a security risk analysis and the results will be included in the Information Security Plan provided during the DDI phase. The risk analysis will also be made available to appropriate Federal agencies. As determined by the State to be appropriate, the following specific security measures may be included in the system design documentation, operating procedures and State agency security program:

a. computer hardware controls that ensure acceptance of data from authorized networks only:

b. placement of software controls, at the Contractor's central facility, that establish separate files for lists of authorized user access and identification codes;

c. manual procedures that provide secure access to the system with minimal risk;

d. multilevel passwords, identification codes or other security procedures that must be used by State or Contractor personnel;

e. all TennCare-POS software changes subject to TennCare approval prior to implementation: and,

f. system operation functions segregated from systems development duties.

A.2.3.8. Disaster Preparedness and Recovery at the Automated Claims Processing Site. The Contractor must submit evidence that they have a Business Continuity/Disaster Recovery plan for their Central Processing Site. If requested, test results of the plan will be made available to TennCare. The plan must be able to meet the requirements of any applicable state and federal regulations, the TennCare Bureau and Tennessee's OIR.

a. After award of the Contract, but during the development of the Information Security Plan, a Contractor representative must work in conjunction with a team member from both OIR and TennCare's TCMIS in order to ensure that the plan is compatible with TCMIS and TennCare policy and procedures.

b. The Contractor must include sufficient information to show that they meet the following requirements:

i. Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc. This documentation must be in the form of a formal Disaster Recovery Plan. The Contractor will apply recognized industry standards governing Disaster Preparedness and Recovery including the ability to continue processing in the event that the central site is rendered inoperable.

ii. Employees at the site must be familiar with the emergency procedures.

iii. Smoking must be prohibited at the site.

iv. Heat and smoke detectors must be installed at the site both in the ceiling and under raised floors (if applicable). These devices must alert the local fire department as well as internal personnel.

v. Portable fire extinguishers must be located in strategic and accessible areas of the site. They must be vividly marked and periodically tested.

vi. The site must be protected by an automatic fire suppressing system.

vii. The site must be backed up by an uninterruptible power source system.

c. The Contractor must describe their 'hot-site' and how quickly TennCare-POS operations can be transferred to that site. TennCare must have direct, "read only" access so that designated staff may review the accuracy of TennCare data on the Contractor's system.

A.2.4. TennCare-POS Reporting Requirements

A.2.4.1. Monthly Claim Activity Reports. The Contractor must produce reports that identify the numbers of, and reasons for, claims adjudicated-paid and adjudicated-denied (according to the TennCare definition of these terms). Reports must separate claims by TennCare-defined provider type. Reports must show at least billed amounts, paid amounts, quantity, days supply, generic drug name, generic drug code, recipient information, prescriber information, etc.

Monthly claim activity reports will also be sent to the MCOs and BHOs for their members in a format defined by TennCare. In addition, claim activity reports must identify paid, denied or rejected claims for each problem type and drug to satisfy federal annual reporting requirements to include, but not be limited to: quantity of batch electronic claims and paper claims received/processed in reporting period, year to date; and quantity of POS claims received/processed in reporting period, year to date. These reports shall be in an electronic format acceptable to TennCare such as MS Excel®.

A.2.4.2. Encounter Reports. Post-adjudicated claims (encounters) must be reported by the Contractor on a schedule designated by TennCare. The current schedule is monthly, however, the schedule may change to correspond with the weekly adjudication cycle of the TCMIS starting in October of 2003. The format and frequency for these encounter reports will be designated by TennCare. NCPDP 1.1 formats are planned after HIPAA implementation.

A.2.4.3. Monthly Batch Claim Operations Reports. The Contractor must provide reports of data entry volumes and types of transactions with daily, weekly and monthly summaries.

A.2.4.4. Monthly Pro-DUR Reports. The Pro-DUR systems capability will provide operational and management reports. The reports listed below indicate the nature of TennCare's interests in this area. The system must produce reports that identify Pro-DUR alert conditions including, but not limited to the following: number of messages generated; number of messages overridden; number of reversals/cancellations/denials; number and types of interventions by pharmacists, and the outcomes of such interventions; and, number and dollar amount of claim adjustments and reversals.

a. The system must compile data and produce reports to demonstrate the cost effectiveness of the Pro-DUR component of the TennCare-POS according to state specifications and federal reporting requirements.

b. The system must generate Pro-DUR management reports that summarize alerts by type, pharmacy, prescribing physician, and other criteria as required by TennCare.

c. The system must allow the export of an electronic file or online system to be used by the Department for further ad hoc analysis of Pro-DUR activity. The format and timing of the production of this file will be defined during the DDI phase.

A.2.4.5. Systems Help Desk and Prior Authorization Call Center Activity Reports. The Contractor must produce reports on usage of the Systems Help Desk and Prior authorization Call Center services, including numbers of inquiries, types of inquiries, and timeliness of responses.

A.2.4.6. Bi-Weekly Status Reports. The Contractor shall provide bi-weekly status reports defined during the Project Initiation Task. At a minimum, the report will include the following topics:

Project Metrics - The Contractor will produce a detailed report listing actual versus planned progress on the schedule for each task. The report will contain statistics showing variance from the critical path. The report should also include graphs depicting estimated trend lines based on actual progress made based on "early finish" and "late finish" scenarios.

Progress Report and Issues List - The bi-weekly report must discuss progress made since the last report. It must list outstanding issues. It should provide a tool for TennCare and the Contractor to manage resources and resolve issues before they have an impact on the project. If corrective action is required, the

status report will present action items that must be accomplished in order to correct the problems.

Performance Level Report - The BI-weekly report must identify measures of each performance level defined in the RFP over the reporting period.

A.2.4.7. *Ad Hoc* Reports. The Contractor must be able to provide, at no extra cost to the State, ad hoc reports to the State which will assist in managing the pharmacy benefit for TennCare members. Ad hoc reports will be provided to the State in a format described by the State and on a reasonable timetable. The Contractor may furnish the State with alternatives to ad hoc reports, such as decision support systems (DSS) capabilities, that address the managerial concerns of the TennCare Bureau which would normally be requested in an ad hoc report, however, the Contractor will still be responsible for responding to requests for ad hoc reports.

A.2.5. Implementation Deadline and Damages

The Contractor shall fully implement the POS system on January 1, 2004. The State shall assess liquidated damages in the amount of ten thousand dollars ($10,000.00) per day for each day full implementation of the project is delayed by fault of the Contractor.

A.3. Preferred Drug List (PDL)

The Contractor will continue to design, develop, implement, administer and maintain a "preferred drug list" (PDL) program for the TennCare pharmacy program. The Contractor will support the TennCare Pharmacy Advisory Committee and present any changes or additions to the TennCare PDL to the Committee explaining the clinical and economic considerations the Contractor used in the continuing development of the PDL. Preferred drugs can be prescribed and dispensed with no prior authorization; non-preferred drugs can be prescribed, but must require prior authorization from the Contractor prior to being dispensed by the pharmacist and reimbursed. The Contractor will develop prior approval criteria for non-preferred drugs and present that criteria to TennCare and the TennCare Advisory Committee for approval. The Contractor will be responsible for negotiating supplemental rebates with pharmaceutical manufacturers for non-preferred drugs. The Contractor will operate a Help Desk with the capability to respond promptly to systems and claims inquiries and a separate Prior Authorization Call Center twenty-four (24) hours a day, seven (7) days a week.

The TennCare PDL shall be designed to maximize the prescribing and dispensing of those safe and clinically effective drugs within each therapeutic class that are the most cost-effective. Conversely, the TennCare PDL should ensure that more costly drugs, which do not have any significant clinical or therapeutic advantage over others in their class, are used only when medically necessary.

The Contractor's PDL design must include a stringent clinical review of medical and scientific data to evaluate which classes of drugs should be subject to the PDL program. Within the classes of drugs determined to be subject to the PDL, the Contractor must determine which drugs within each class are safe, clinically effective, and provide equivalent clinical outcomes. Recommendations for inclusion on the PDL shall be based on a thorough review of clinical effectiveness, safety, and health outcomes, followed by an analysis of the relative costs of the drugs in each class under consideration.

The Contractor will evaluate all potential mechanisms ranging from flat supplemental rebates for drugs excluded from the PDL to a reference price for drugs in each therapeutic class subject to PDL. Those drugs deemed first to be safe and clinically effective that are at or below the reference price for the therapeutic class would be identified as preferred drugs. Manufacturers whose price for a particular drug within a given therapeutic class is above the reference price would be offered the opportunity to provide supplemental rebates to bring the State's cost for their more expensive products

to a level comparable to the reference price. After the final PDL is delivered to TennCare, the Contractor will compare and contrast for the State the different supplemental rebate strategies that may be employed and the clinical and economic ramifications of each strategy.

The Contractor will negotiate and manage the supplemental rebate process as required by TennCare following review of the compare/contrast report developed by the Contractor. Those drugs that are excluded from the PDL would be considered non-preferred and require prior authorization by the Contractor's Prior authorization Unit in order to be dispensed to a TennCare member.

The Contractor may establish policy and procedures describing the manner in which pharmaceutical manufacturer industry personnel contact appropriate Contractor staff. This may include specifying which Contractor staff may be contacted and the content of discussions when contact or visits take place. Further, Contractor reserves the right to restrict these contacts and visits to pharmaceutical manufacturer personnel appropriate to discussions related to the TennCare PDL. The Contractor shall work with TennCare in establishing policy that guides the content of discussion and forum for such discussions with pharmaceutical manufacturers as they relate to the TennCare PDL. Nothing in this Contract shall constrain the Contractor from engaging in contact with manufacturer personnel on behalf of other Contractor clients.

Prescribers will be required to obtain a prior authorization for all non-preferred drugs in each class through a Prior Authorization Call Center, provided by the Contractor, staffed with appropriate clinicians, and/or through written communications (e.g., fax, mail). Call Center representatives will provide a determination as to whether it is appropriate or medically necessary for the specific patient to receive a non-preferred drug. A reconsideration process, performed by a physician, must be maintained to ensure the ability of prescribers to have any potential denials reviewed.

The Contractor will design, develop, test and implement an electronic interface with the Contractor's POS pharmacy claims processing system to assure timely transmission and uploading (posting) of prior authorization data from the Prior Authorization Call Center to the TennCare-POS pharmacy system.

The Contractor will design, develop and implement an educational effort designed to assure that prescribers and pharmacists are fully aware of the TennCare PDL and prior authorization requirements. The Contractor will submit educational plans to TennCare for review and approval, prior to implementation.

The Contractor will monitor compliance with the TennCare PDL, report that information to TennCare monthly, and provide suggestions for improving PDL compliance.

The Contractor shall ensure that supplemental rebates exceed federal rebates as required by Section 1927 of the Social Security Act and complies with CMS guidelines, regulations and policies.

The supplemental rebates for 2003 which are billed in 2004 will be the obligation of the Contractor of record as of January 1, 2004.

A.3.1. PDL Design, Development, and Implementation

A.3.1.1. The Contractor shall use pharmacoeconomic modeling and evidence-based data in the development of the TennCare PDL that would ensure clinically safe and effective pharmaceutical care and yield the highest overall level of cost effectiveness. The Contractor will develop and submit to TennCare a schedule for review, approval and implementation of the TennCare PDL that meets the State's pharmacy program goals and timelines. The Contractor will develop and present to the TennCare Pharmacy Advisory Committee the clinical and pharmacoeconomic review criteria the Contractor used to determine preferred

and non-preferred drugs and specific written guidelines for the criteria to be used and the administration of the prior authorization of non-preferred drugs.

A.3.1.2. The Contractor will design, develop, implement and maintain a 24-hour Prior authorization Call Center to conduct prior authorization reviews for non-preferred drugs.

A.3.1.3. The Contractor will design, develop and implement an ongoing, broad-based educational effort to ensure that prescribers and pharmacists are fully aware of the TennCare PDL and prior authorization requirements. The Contractor will submit educational plans to TennCare for review and approval, prior to implementation

A.3.1.4. The Contractor will negotiate supplemental rebates with pharmaceutical manufacturers as part of the TennCare PDL program. The resulting contract, negotiated by the Contractor and approved by TennCare, regarding supplemental rebates shall be between the pharmaceutical manufacturer and the State. The Supplemental Rebate Contract will be written using the template attached as Attachment 7.7 of RFP 3183.65-128, as approved by CMS. The Contractor will establish and operate a process for accurate reporting and monitoring of negotiated supplemental rebate payments and perform all supplemental rebate dispute resolutions to maximize collections for the State.

A.3.1.5. The Contractor, consistent with State guidelines and requirements, will provide annual opportunities for manufacturers to amend supplemental rebate agreements. However, nothing in this contract would prevent a manufacturer from offering supplemental or enhanced rebates or amendments to existing supplemental rebates at any time. The Contractor will report to TennCare, on a time schedule and in a format specified by TennCare, the results of those negotiations and their clinical and fiscal impact on the PDL. TennCare shall have final approval on all supplemental rebate agreements and amendments.

A.3.1.6. The Contractor shall ensure that the TennCare-POS pharmacy claims processing system fully integrates the TennCare PDL and prior authorization programs.

A.3.1.7. During the life of this contract, the Contractor will comply with all applicable federal and state statutes, regulations, rules and policy requirements and all applicable administrative rules, statutes, policies and guidelines.

A.3.1.8. The Contractor will ensure that the TennCare PDL program and TennCare-POS system include provisions for:

a. the dispensing of an emergency supply, as described and determined by TennCare policy, of the prescribed drug and a dispensing fee to be paid to the pharmacy for such supply;

b. prior authorization decisions to be made within 24 hours and timely notification of the prescribing physician; and

c. prescriber and pharmacy provider education, training and information regarding the TennCare PDL prior to implementation, and ongoing communications to include computer and website access to information.

A.3.1.9. The Contractor will ensure that all prescribers and pharmacy providers have timely and complete information about all drugs on the TennCare PDL. The Contractor shall make such information available through written materials, internet sites, and electronic personal data assistants (PDA).

A.3.1.10. The Contractor will support the management and coordination of all activities related to the maintenance of the TennCare PDL. Activities will include but not be limited to the following:

- The Contractor will present the TennCare Pharmacy Advisory Committee clinical reviews of new brand-name drugs and new generic drugs for clinical safety and efficacy, and make recommendations regarding possible inclusion in the TennCare PDL.
- The Contractor will present the TennCare Pharmacy Advisory Committee clinical review of existing drugs for new indications or changes to indications that might affect their inclusion in the TennCare PDL.
- The Contractor will annually review drugs within chosen therapeutic classes in order to affirm or change the recommendations to TennCare regarding supplemental rebate strategies.
- The Contractor will develop changes to drug review criteria for the TennCare PDL based on new clinical and pharmacoeconomic information.
- The Contractor will analyze cost information relative to drug alternatives as they affect the TennCare PDL.
- The Contractor will monitor compliance with the TennCare PDL, report that information to TennCare monthly and quarterly, and provide suggestions for improving PDL compliance.

A.3.1.11. The Contractor will attend, support and facilitate meetings of the TennCare Pharmacy Advisory Committee as necessary to maintain the TennCare PDL.

A.3.1.12. The Contractor shall, concurrent with the development of the PDL, conduct meetings with TennCare to develop and analyze the different potential supplemental rebate strategies with the designated pharmaceutical manufacturers.

A.3.1.13. The Contractor shall, subject to TennCare approval, negotiate supplemental rebate agreements with pharmaceutical manufacturers. Such agreements will be in a format agreed to by TennCare and approved by CMS. TennCare will review and approve agreements prior to execution.

A.3.1.14. The Contractor shall provide TennCare with access to all supplemental rebate contracts and related documentation.

A.3.1.15. The Contractor shall ensure that supplemental rebates exceed federal rebates as required by Section 1927 of the Social Security Act.

A.3.1.16. The Contractor shall maintain the State's supplemental rebate contracts confidentially and separate from its other clients. The Contractor will propose a plan for securing and maintaining the supplemental rebate contracts and related confidential information in a format agreed to by TennCare. TennCare must approve confidentiality agreements.

A.3.1.17. The Contractor shall perform supplemental rebate calculations including National Drug Code (NDC) information and invoice the manufacturers within 30-45 days after end of each calendar quarter. The invoices must be approved by TennCare and contain information sufficient to minimize disputes and comply with supplemental rebate contracts with the manufacturers.

A.3.1.18. The Contractor will perform all dispute resolution activities with pharmaceutical manufacturers as they pertain to supplemental rebate calculations and collections. One hundred percent (100%) of the supplemental rebates collected pursuant to implementation of the TennCare PDL, on behalf of the state, will be remitted to the State. The Contractor agrees that all rebates collected on behalf of the State will be collected for the sole benefit of the state share of costs.

A.3.1.19. The Contractor will provide to TennCare monthly and ad hoc reports on the performance of the TennCare PDL and supplemental rebates, in a format acceptable to TennCare.

A.3.2. Administer Prior Authorization Program for the TennCare PDL

A.3.2.1. In instances where pharmaceutical manufacturers and labelers do not sign supplemental rebate agreements with the State for drugs within selected therapeutic categories, those drugs will be given a status of "non-preferred." Prescriptions for non-preferred drugs will require prior authorization.

A.3.2.2. The Contractor shall develop clinical prior authorization review criteria. CMS-approved reference books as well as current medical literature may be used to develop the criteria. The Contractor shall make all TennCare-approved prior authorization review criteria easily understood and widely available to TennCare providers through various media. The Contractor will also present all prior authorization review criteria to the TennCare Pharmacy Advisory Committee prior to implementation.

A.3.2.3. The Contractor shall develop a plan for administering the prior authorization program. The plan should achieve the objective of compliance with the PDL without unduly disrupting access to care or increasing provider costs, and demonstrate the means by which this will be accomplished.

A.3.2.4. The Contractor shall provide prior authorization services for prescriptions written for non-preferred drugs. Prior authorization services will consist of prescription review by a licensed pharmacist or pharmacy technician to ensure that all predetermined clinically appropriate criteria have been met before the prescription may be dispensed and subsequently reimbursed.

A.3.2.5. The Contractor shall have an automated approval process for prior authorization based on the member's specific drug history with an emphasis on reduction of transactions and manual interventions.

A.3.2.6. The Contractor shall ensure that all prior authorizations conducted via the telephone meet the service and quality standards required by TennCare in this contract.

A.3.2.7. The Contractor shall pre-test prior authorization procedures with physicians and pharmacists prior to implementation to ensure that the process is working as designed.

A.3.3. Provide TennCare PDL and Prior Authorization Program Education Services

A.3.3.1. The Contractor shall develop and implement an effective education program for providers that explains how the TennCare PDL and prior authorization programs operate. The education program initiative must begin prior to the effective date of the TennCare PDL and prior authorization programs and continue on an ongoing basis.

A.3.3.2. The Contractor shall develop notification and education strategies for TennCare providers. Educational topics will include, at a minimum, PDL program intent, the process that was used to develop the TennCare PDL and prior authorization programs, the prior authorization review criteria, the processes that will be followed upon implementation and the prescriber reconsideration process for denied prior authorizations.

A.3.3.3. The Contractor shall provide an information plan detailing education to TennCare providers regarding the TennCare PDL and associated prior authorization programs. The Contractor shall provide education and notification processes and methods designed to increase TennCare PDL compliance rates and minimize transition disruptions.

A.3.3.4. The Contractor shall assign one or more of its pharmacists to perform the duties of Education Specialist. The Education Specialist will be responsible for the execution of the TennCare-approved communication strategies that will be developed for TennCare provider groups.

A.3.3.5. The Contractor shall develop and produce, with TennCare approval, program material and provide to TennCare for distribution through mailings and directly by the Education Specialists to provider groups.

A.3.3.6. The Contractor shall implement the agreed upon communication strategies through direct involvement with prescribers and pharmacy providers and a combination of site visits, telephone support, internet-based application, and direct mail.

A.3.4. Prior Authorization Reconsideration

The Contractor shall have a reconsideration process, administered by a board certified physician, in place available to providers who wish to challenge adverse prior authorization decisions. This process must ensure that appropriate decisions are made and communicated to the prescriber within twenty-four (24) hours of the initial request by a physician. The Contractor must develop policies and procedures regarding the reconsideration processes. These must be reviewed and approved by TennCare prior to implementation. The Contractor shall notify providers of the reconsideration process with respect to re-review of adverse prior authorization decisions. The Contractor will provide TennCare with monthly reports indicating the number of reconsideration requests, analysis and disposition.

A.3.5. Prior Authorization Call Center

A.3.5.1 The Prior Authorization Call Center shall provide toll-free telephone and facsimile access for providers (in-state and out-of state) to support prior authorizations and other program initiatives twenty-four (24) hours a day, seven (7) days a week, ensure that qualified personnel responding to prior authorization requests are fully trained and knowledgeable about TennCare standards and protocols, have the capacity to handle all telephone calls and facsimiles at all times and have the upgrade ability to handle any additional call or facsimile volume. Any additional staff or equipment needs will be the responsibility of the Contractor. The Contractor is responsible for adequate staffing and equipment at all times, especially during high peak times.

The Prior Authorization Call Center shall provide sufficient telecommunications capacity to meet TennCare's needs with acceptable call completion and abandonment rates as specified in the performance standards below. This capacity must be scalable (both increases and decreases) to demand in the future.

The Prior Authorization Call Center shall provide registered pharmacists during all hours of call center operation to respond to pharmacy related questions that require clinical interventions, reconsiderations and consultation and provide physician support for responses to prior authorization request reconsiderations.

The Prior Authorization Call Center shall effectively manage all calls received by the automated call distributor and assign incoming calls to available staff in an efficient manner.

The Prior Authorization Call Center must process prior authorization requests from prescribers via facsimile transmission, telephone, and U.S. Mail. These forms of requests shall be reviewed by qualified personnel who are fully trained and knowledgeable about TennCare standards and protocols and shall also be responded to within twenty-four (24) hours of receipt one hundred percent (100%) of the time.

The Contractor shall develop a prior authorization form for prescribers to use when sending a request via facsimile. TennCare will review and approve the PA form prior to its distribution by the Contractor.

The Contractor will provide TennCare with all Prior Authorization Call Center toll-free telephone and facsimile numbers, as well as the appropriate mailing address for prior authorization requests, prior to December 15, 2003. The Contractor will also distribute these numbers to providers at all training and provider education sessions.

Failure by the Contractor to provide Prior Authorization Call Center numbers and addresses by December 15, 2003 or failure to distribute these numbers and addresses to providers at all training and provider education sessions may result in the assessment of liquidated damages by TennCare of one thousand dollars ($1,000.00) per day until this requirement is satisfied.

A.3.5.2. The Contractor is responsible for meeting the following performance standards and is required to provide reports demonstrating that it has performed as follows:

- The Prior Authorization Call Center shall be available twenty-four (24) hours a day, seven (7) days a week, to respond to prior authorization requests, except for prior, written, TennCare-approved downtime.
- The Contractor shall provide sufficient staff, facilities, and technology such that ninety-five percent (95%) of all call line inquiry attempts are answered. Answer percentage rate shall be defined as (ACD calls)/ (ACD calls + Abandoned calls). The total number of abandoned calls shall not exceed five percent (5%) in any calendar month.
- Calls must be answered within thirty (30) seconds. If an automated voice response system is used as an initial response to inquiries, an option must exist that allows the caller to speak directly with an operator. The Contractor shall provide sufficient staff such that average wait time on hold per calendar month shall not be in excess of thirty (30) seconds.
- All call line inquiries that require a call back, including general inquiries, shall be returned within 1 business day of receipt one hundred percent (100%) of the time.

Failure by the Contractor to comply with the Prior Authorization Call Center performance standards may result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day per performance standard during the first month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day per violation for the second consecutive month violations are identified. TennCare will monitor the Call Center and notify the Contractor of any violations of the performance standards as well as any possible sanctions related to those violations. The Contractor will have seventy-two (72) hours, following written notification, to correct all violations prior to the assessment of liquidated damages by TennCare. The Contractor shall submit to TennCare, within twenty-four (24) hours, a written corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

A.3.5.3. The Prior Authorization Call Center shall also process prior authorization requests from prescribers via facsimile transmission and U.S. Mail. These forms of requests shall also be responded to within twenty-four (24) hours of receipt one hundred percent (100%) of the time.

Failure by the Contractor to comply with the Prior Authorization Call Center performance standards for facsimile and U.S Mail prior authorization requests as required by this Contract may result in the assessment of liquidated damages by

TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day per violation for the second consecutive month violations are identified. TennCare will notify the Contractor of any violations of these performance standards as well as any possible sanctions related to those violations. The Contractor will have seventy-two (72) hours, following written notification, to correct all violations prior to assessment of liquidated damages by TennCare. The Contractor shall submit to TennCare, within twenty-four (24) hours, a written corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

A.3.5.4. Prior Authorization Call Center Reporting

Prior Authorization Call Center reporting shall be provided monthly, by the fifteenth (15th) day of the following month, and, at a minimum, shall include the following:

- Total hours of daily call center access provided, and any downtime experienced.
- Call abandonment rate, and average abandon time.
- Average answer speed in seconds.
- Comprehensive report on the nature of interventions requested, with counts of the twenty most frequent types of interventions handled during the month.
- Intervention volume by prescriber and pharmacy, with indication of the key types of interventions being received, including drug names and categories.
- Average ACD time of calls handled.
- Total number of intervention requests received.
- Total number of PA requests processed.
- Total number of PA requests approved.
- Total number of PA requests denied.
- Total number of intervention requests received via telephone.
- Total number of intervention requests received via facsimile.
- Total number of intervention requests received via U.S. Mail.
- Total number and types of complaints received from TennCare enrollees regarding any difficulties receiving pharmacy services under the TennCare Pharmacy Program.

The Prior Authorization Call Center reports shall be delivered to TennCare in electronic format, such as MS Excel® and hardcopy, as described by TennCare. The reports shall be due on the fifteenth (15th) day of the month for the previous month's Prior Authorization Call Center activity.

Failure by the Contractor to provide the Prior Authorization Call Center reports listed above in a complete and timely manner may result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages will increase to two

hundred dollars ($200) per day for the second consecutive month violations are identified. TennCare will review the Prior Authorization Call Center reports and notify the Contractor of any violations of the requirements as well as any possible sanctions related to those violations. The Contractor will have seventy-two (72) hours, following written notification, to correct all violations prior to the assessment of liquidated damages by TennCare. The Contractor shall submit to TennCare, within twenty-four (24) hours, a written corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

A.3.5.5. Prior Authorization Process

The Contractor's telephonic Prior Authorization process flow must be approved by TennCare prior to December 15, 2003. Upon receipt of the call, the pharmacy technician at the Prior Authorization Call Center will query patient/drug information.

If the request is consistent with the prior authorization/medical necessity criteria developed by Contractor and approved by TennCare and the TennCare Pharmacy Advisory Committee, the technician will document the call in the Contractor pharmacy case management system and the system will post the PA in TennCare-POS system.

If the request is not consistent with the prior authorization/medical necessity criteria and protocols and the prescriber wishes to have the request escalated, the call will be transferred to the clinical pharmacist on the Prior Authorization Call Center. If upon review, the clinical pharmacist finds sufficient justification, the request should be documented and the PA posted in the TennCare-POS system. If sufficient justification is not evident this is documented as well. If the request requires further escalation or the prescriber requests reconsideration of a denied PA request, the request will be forwarded to the Contractor's physician for reconsideration and final review.

If a TennCare enrollee files an appeal subsequent to the denial of a prior authorization request by a prescriber, the Contractor, upon notice of the appeal from the TennCare Solutions Unit (TSU), shall produce and deliver to the TSU all pertinent information regarding that particular prior authorization request by the close of business in two (2) business days.

A.3.5.6. Hours of Operation

The Contractor will operate its Prior Authorization Call Center twenty-four (24) hours a day, seven (7) days a week. Pharmacists will be staffed onsite between the hours of 6 am and 10 pm Monday through Friday and 9am to 3pm on Saturdays (all times are Central Time). Pharmacists shall be on call outside of onsite hours and able to respond to prior authorization requests, if necessary, within one (1) hour of the request.

The Contractor must furnish specific telephone numbers for TennCare Solutions Unit (TSU) staff to contact after normal business hours and during weekends and holidays in order to assure eligibility and coverage issues can be addressed and corrected pursuant to an appeal by a TennCare enrollee. The Contractor's supervisory personnel must be trained to recognize TSU staff and respond to their telephone calls immediately. TSU may require the Contractor's staff to enter a TennCare enrollee's eligibility information and allow processing of pharmacy claims in "after-hours" situations.

A.3.5.7. The Contractor shall provide and maintain a toll-free telephone Prior Authorization Call Center, as described above, for TennCare providers. As it is anticipated that a significant number of the prior authorization requests for the

TennCare PDL and other associated prior authorizations shall be received through the call center, TennCare requires a highly effective and responsive operation.

A.3.5.8. The Contractor shall install, operate, monitor and support an automated call distribution system that has capability to accept prior authorization requests via telephone, facsimile, U.S. mail or e-mail. The Prior Authorization Call Center is to be utilized for complete prior authorization decisions, handle complaints and reconsiderations and make final determinations associated with the TennCare PDL and other associated prior authorization programs or processes, provide technical and clinical support functions for prescribers and pharmacists who request assistance on how to complete the functions described under this contract and provide general information about any new pharmacy programs in response to inquiries.

A.3.5.9. TennCare requires a reconsideration process when the initial review of prescriber prior authorization information would result in a denial. The Contractor's staff must respond to reconsideration requests within twenty-four (24) hours, while maintaining confidentiality of information. Contractor staff must be consistently responsive, helpful and courteous when responding to the inquiries received via the call center.

A.3.5.10. The Contractor will be responsible for a Quality Assurance program which shall be in place to sample calls and follow up calls to confirm the quality of responses, and caller satisfaction. The Contractor is responsible for providing quarterly reports on the outcomes of the Quality Assurance program, and any training required to maintain the highest level of quality.

A.3.5.11. The Contractor shall design and implement a management call tracking and reporting capability including an electronic record to document a synopsis of all calls and to provide a complete record of communication to the call line from providers and other interested parties, provide complete online access by TennCare to all computer files and databases that support the system for applicable pharmacy programs and develop, maintain, and ensure compliance with TennCare confidentiality procedures/policies, including HIPAA requirements, within the call line department.

A.3.5.12. The Prior Authorization Call Center shall provide a greeting message when necessary and educational messages approved by TennCare while callers are on hold, install and maintain its telephone line in a way that allows calls to be monitored by a third party for the purposes of evaluating Contractor performance with a message which informs callers that such monitoring is occurring. Call monitoring by a third party, for accuracy and quality of information, must be available at the location of the call center.

A.3.5.13. The Prior Authorization Call Center shall ensure that there is a back-up telephone system in place that will operate in the event of line trouble or other problems so that access to the call center by telephone is not disrupted.

A.3.5.14. Pharmacy technicians may handle all initial prior authorization requests taken at the call center, however any prior authorization denial must be determined or approved by a registered (licensed) pharmacist on duty at the Prior Authorization Call Center. A physician must review all reconsideration requests for denials and must be available via telephone at all times for clinical support.

A.3.6. Pharmacy Clinical Manager

The Contractor will provide a Pharmacy Clinical Manager to offer clinical program support to TennCare. The Clinical Manager assigned to this project must be a licensed pharmacist with a Pharm.D. degree from an accredited pharmacy

school and approved by TennCare. If it becomes necessary for the Contractor to replace the Clinical Manager, the Contractor will notify TennCare within three (3) business days of the change.

A.3.7. TennCare PDL Reporting Requirements

The Contractor shall submit accurate and complete management reports to TennCare as described in this contract. All reports, analyses, and/or publications developed under this contract will be the property of TennCare. TennCare reserves the right to change reporting requirements and request ad hoc reports. Reports shall include, but not be limited to, Prior Authorization Call Center reports, reports on the number and type of complaints, reports that track the prior authorization activities such as the number of service denials, the number of reconsideration requests by prescribers for prior authorization denials and the outcomes. Reports shall be separated for prior authorizations associated with the TennCare PDL and prior authorizations for any other prior authorization processes or edit overrides.

The Contractor will provide TennCare with monthly utilization management reporting. As clinical programs are implemented, the Contractor's clinical staff will define regular reports designed to gauge the effectiveness of each initiative, including movement of market share within given therapeutic categories of the TennCare PDL. The Contractor's utilization management reporting package will be customizable to meet TennCare program analysis needs. The Contractor's utilization management reporting will contain flexible ad hoc reporting through the Contractor's web-based, DSS system.

The Contractor's monthly utilization management reports will also include financial data that provide summary drug costs by therapeutic category, by specific drugs, by behavioral health drug categories, by dual member categories and by MCO member, medical drug categories. These reports will also detail supplemental rebate data that demonstrates by drug and by drug category the actual supplemental rebates paid by the pharmaceutical manufacturers.

The Contractor must submit the monthly utilization management reports to TennCare, on or before the fifteenth day of the following month.

Failure by the Contractor to provide the Utilization Management reports listed above in a complete and timely manner may result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day for the second consecutive month violations are identified. TennCare will review the Utilization Management reports and notify the Contractor of any violations of the requirements as well as any possible sanctions related to those violations. The Contractor will have thirty (30) calendar days, following written notification, to correct all violations prior to assessment of liquidated damages by TennCare. The Contractor shall submit to TennCare, within five (5) business days, a corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

A.3.8. Post Implementation PDL Reports. The Contractor shall produce the following monthly reports in a format (such as MS Excel®) acceptable to TennCare:

a. Monthly Cost Savings/Avoidance Report to include: utilization shifts by drug and drug class; cost savings resulting from changes in prescribing,

by drug and drug class; compliance with TennCare PDL drug classes by prescribers; expenditure per claim comparison (monthly/quarterly/yearly).

b. Quarterly evaluation of the effectiveness of the TennCare PDL and prior authorization programs, including recommendations for changes to TennCare PDL drugs, the criteria for review and approval of drugs, and protocols and procedures.

c. Monthly Supplemental Rebate Negotiations Status Report on underway and completed, the status of negotiation outcomes and the product-specific financial impact of the supplemental rebates on the TennCare PDL.

d. Quarterly report on supplemental rebate invoicing including calculations of the net cost of effected drugs to TennCare.

e. Report on Total Estimated and Projected Future Savings from the TennCare PDL and prior authorization programs (monthly for the initial twelve (12) months of this contract and quarterly thereafter).

f. Quarterly reports demonstrating the nature and extent of educational interventions to outlier prescribers, and the outcomes of those interventions.

The Contractor must submit the monthly Post Implementation PDL reports to TennCare, on or before the fifteenth day of the following month.

Failure by the Contractor to provide the Post Implementation PDL reports described above in a complete and timely manner may result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day for the second consecutive month violations are identified. TennCare will review the Utilization Management reports and notify the Contractor of any violations of the requirements as well as any possible sanctions related to those violations. The Contractor will have seventy-two (72) hours, following written notification, to correct all violations prior to assessment of liquidated damages by TennCare. The Contractor shall submit to TennCare, within twenty-four (24) hours, a written corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

A.4. Website

TennCare requires that the Contractor provide a secure electronic based communications system for e-mail other than prior authorization requests. The system should provide a website with information associated with the TennCare PDL and prior authorization process as well as TennCare policies and procedures that have been put in place as a result of the contract. The system must be able to be easily customized and have interactive communication capabilities to meet the needs of TennCare and its providers. Confidentiality policies and procedures are of the utmost importance to TennCare. The Contractor must provide support and maintenance of the website and guarantee any data exchange between the Contractor and TennCare or its providers will be secure.

A.5. Readiness Review

The State may conduct an on-site review to assess the readiness of the Contractor to effectively administer and provide the services as defined in the Contract.

A.6. Program Integrity Requirements. The Contractor must have TennCare-approved policies and procedures in place for ensuring protections against actual or potential fraud and abuse. The Contractor must have a detailed Program Integrity Plan. The Program Integrity Plan must define how the Contractor will adequately identify and report suspected fraud and abuse by recipients, providers, by subcontractors and by the Contractor. The Program Integrity Plan must be submitted annually and must discuss the monitoring tools and controls necessary to protect against theft, embezzlement, fraudulent practices or other types of fraud and program abuse, and describe the type and frequency of training that will be provided to detect fraud. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the State of Tennessee and/or Federal laws and regulations. The Contractor's Program Integrity Plan must address the following requirements:

a. Written Policies and Procedures. The Contractor shall develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State Standards for the prevention, detection and reporting of incidents of potential fraud and abuse by members, providers, by subcontractors and by the Contractor.

b. Compliance Officer. The Contractor shall designate a compliance officer and a compliance committee, accountable to senior management, to coordinate with TennCare and other state agencies on any fraud or abuse case. The Contractor may identify different contacts for member fraud and abuse, provider fraud and abuse, subcontractor fraud and abuse, and Contractor fraud and abuse.

c. Training and Education. The Contractor shall establish effective program integrity training and education for the Compliance Officer and all Contractor staff.

d. Effective Lines of Communication between Contractor Staff. The Contractor shall establish effective lines of communication between the compliance officer and other Contractor staff.

e. Well-Publicized Disciplinary Guidelines. The Contractor shall enforce program integrity standards through well-publicized disciplinary guidelines.

f. Internal Monitoring and Audit. The Contractor shall establish and implement provisions for internal monitoring and auditing.

g. Process for Reporting Potential or Actual Fraud and Abuse. The Contractor shall provide information and a procedure for members, providers and subcontractors to report incidents of potential or actual fraud and abuse to the Contractor and to TennCare.

h. Prompt Response to Reported Offenses. The Contractor shall report all potential or actual fraud and abuse to TennCare or other appropriate state agencies.

i. Development of Corrective Action Initiatives. The Contractor's program integrity plan shall include provisions for corrective action initiatives.

j. Time Frame for Reporting Fraud and Abuse to the Department. The Contractor shall report incidents of potential or actual fraud and abuse to TennCare within forty-eight (48) hours of initiation of any investigative action by the Contractor or within forty-eight (48) hours of Contractor notification that another entity is conducting such an investigation of the Contractor, network providers, or the members. All reports shall be sent to TennCare in writing and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities.

k. Cooperation with State and Federal Investigations. The Contractor shall cooperate with all fraud and abuse investigation efforts by TennCare and other State and Federal offices.

A.7. Confidentiality of Information

The Contractor shall maintain the confidentiality of TennCare member information. The Contractor shall ensure that access to this information will be limited to the Contractor. The Contractor shall take measures to prudently safeguard and protect unauthorized disclosure of TennCare member information in its possession. The Contractor shall establish internal policies to ensure compliance with Federal and State laws and regulations regarding confidentiality including, but not limited to, 42 CFR § 431, Subpart F, and all applicable Tennessee statutes and TennCare rules and regulations. In no event may the Contractor provide, grant, allow, or otherwise give, access to TennCare member information to anyone without the express written permission of TennCare. The Contractor shall assume all liabilities under both State and Federal law in the event that the information is disclosed in any manner.

Upon the Contractor's receipt of any requests for TennCare member information from any individual, entity, corporation, partnership or otherwise, the Contractor shall notify TennCare within twenty-four (24) hours or on the next business day. In cases where the information requested by outside sources is releasable under the Freedom of Information Act (FOIA), as determined by TennCare, the Contractor shall provide support for copying and invoicing such documents at the Contractor's expense.

A.7.1. The Contractor shall comply with all federal and state laws and regulations with regard to handling, processing, and using health care data. The Contractor must keep abreast of the regulations and be able to reach full compliance within the specified timeframes. Since HIPAA is federal law and its enacting regulations apply to all health care information, the Contractor must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations at no additional cost to TennCare.

A.7.2. TennCare and the Contractor, as defined in section 160.103 of the Final HIPAA Privacy Rule, will enter into an Agreement which constitutes a Business Associate Agreement to comply with the HIPAA Privacy regulation requirements effective April 14, 2003.

A.7.3. The Contractor shall not use Protected Health Information (PHI) otherwise than as expressly permitted, or as required by law. The Contractor shall ensure that any agents and subcontractors to whom it provides PHI received from TennCare agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor.

A.7.4. The Contractor shall report to TennCare within thirty (30) days of discovery, any use or disclosure of PHI made in violation of agreement or any law. The Contractor shall implement and maintain sanctions for any employee, subcontractor, or agent who violates the requirements of this contract or the HIPAA privacy regulations.

A.7.5. The Contractor shall make an individual's PHI available to TennCare within thirty (30) days of an individual's request for such information as notified by TennCare.

A.7.6. The Contractor shall make PHI available for amendment and correction and shall incorporate any amendments or corrections to PHI within thirty (30) days of notification by TennCare.

A.7.7. TennCare may immediately terminate a Business Associate Agreement with the Contractor if TennCare determines that the Contractor has violated a material term of the agreement.

A.7.8. The Contractor shall submit a written Business Associate Data Security Plan within thirty (30) days of the execution of a Business Associate Agreement. The Business Associate Data Security Plan shall describe the manner in which the Contractor will use TennCare's data and the procedures the Contractor will employ to secure the data.

A.8. Third Party Administrator Requirement

The Contractor shall qualify as an Administrator (a.k.a., "Third Party Administrator") in compliance with ***Tennessee Code Annotated***, § 55-6-401, *et seq.* and shall be licensed to operate as an adjuster or settler of claims in connection with pharmacy benefits coverage in the State of Tennessee and shall be capable of providing or arranging for health care services provided to covered persons for whom it received payment and is engaged in said business and is willing to do so upon and subject to the terms and conditions hereof.

If during the life of this contract, TennCare directs the Contractor, through a contract amendment, to operate as a risk-bearing entity for pharmacy services, the Contractor shall establish and maintain all financial reserves required by the Tennessee Department of Commerce and Insurance of HMOs, Third Party Administrator, or Prepaid Limited Health Services Organization licensed by the State of Tennessee, including, but not limited to, the reserves required by ***Tennessee Code Annotated***, § 56-32-212 as amended or ***Tennessee Code Annotated***, § 56-51-136 as amended. The Contractor shall demonstrate evidence of its compliance (or process of compliance) with this provision to the Tennessee Department of Commerce and Insurance, TennCare Division, in the financial reports filed with that Department by the Contractor.

A.9. TennCare Pharmacy Staff and TennCare MCO Pharmacy and Utilization Staff Online Access

The Contractor shall provide the TennCare Pharmacy Unit and other appropriate TennCare staff individual access, at no additional cost to TennCare, to the Contractor's POS claims history system, prior authorization system, eligibility files and other information as necessary via an online, real time connection. The TennCare managed care organizations (MCOs) must have access to their enrollees' pharmacy claims data in an online, real time manner to effectively perform case management and utilization management processes. The Contractor will provide secure access to the systems and data described above for each TennCare MCO's appropriate staff.

A.10. TennCare Specialty Pharmacy Services

The Contractor will implement a process for the delivery of specialty pharmacy services to TennCare members. Specialty pharmacy services include the provision of specialized contract pharmacy and related services for the treatment of certain chronic, costly diseases such as hemophilia, multiple sclerosis, growth disorders, Crohn's disease, thyroid disorders, Gaucher's disease, organ transplants and other biotech and injectable drugs. Specialty pharmacy services may be delivered by network pharmacies or mail order services that greatly reduce the costs of these drugs. The Contractor will develop for TennCare approval the prior authorization criteria for all specialty pharmacy services.

A.11. TennCare Member Identification Cards

The Contractor shall provide each TennCare member with a permanent pharmacy benefit identification card by February 1, 2004. The card shall comply with all state laws and NCPDP guidelines regarding the information required on the card. The card shall also list any appropriate copays for the member and an effective date for the card. The Contractor shall provide pharmacy benefit identification cards for new TennCare members added to the TennCare eligibility file on an ongoing basis.

A.12. Diabetic Supplies

The Contractor will include diabetic supplies such as syringes, lancets, strips, glucose control solutions and glucose testing monitors in the TennCare-POS pharmacy claims processing system and the Contractor will present to TennCare options for cost

containment of these products through mechanisms such as manufacturer discounts or enhanced rebates and Pro-DUR cost-avoidance edits.

A.13. Contractor Transition

A.13.1. At the expiration of this Contract, or if at any time the state or Contractor should terminate this Contract, the Contractor will cooperate with any subsequent Contractor who might assume operation of the TennCare pharmacy program. The state will give the Contractor sixty (60) days notice that a transfer will occur. TennCare will withhold final payment to the Contractor until transition to the new Contractor is complete.

A.13.2. In the event that a subsequent TennCare-POS operator is unable to assume operations on the planned date for transfer, the Contractor will continue to perform TennCare-POS operations on a month to month basis for up to six months beyond the planned transfer date at the most recently effective monthly payment rate (refer to Contract Section C).

A.14. The Emergency Supply Override

The Contractor will assure that the TennCare-POS system allows pharmacists to execute an emergency or "*Grier* Override" that will process an emergency supply of drugs in normally covered therapeutic categories that are not listed on the TennCare PDL. The Contractor's TennCare-POS system must post a message for the dispensing pharmacist to contact the prescriber and suggest alternative therapies listed on the TennCare PDL. Drugs eligible for the emergency or *Grier* Override must be in a therapeutic class normally covered by TennCare. The Contractor will instruct pharmacy providers how to perform the *Grier* Override in the National Council of Prescription Drug Programs (NCPDP) environment of the TennCare-POS pharmacy claims processing system.

Failure by the Contractor to allow the POS emergency or *Grier* Override for all appropriate, emergency claims may result in the assessment of liquidated damages by TennCare of two hundred dollars ($200) per day during the first month violations are identified. Liquidated damages will increase to four hundred dollars ($400) per day for the second consecutive month violations are identified. TennCare will monitor emergency or *Grier* Overrides and notify the Contractor of any violations as well as any possible sanctions related to those violations. The Contractor will have seventy-two (72) hours, following written notification, to correct all violations prior to assessment of liquidated damages by TennCare. The Contractor shall submit to TennCare, within twenty-four (24) hours, a written corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

A.15. Emergency or *Grier* Override Aggregate Reports

The Contractor will provide TennCare with monthly emergency or *Grier* Override aggregate reports that list the top 100 pharmacies entering emergency or *Grier* Overrides and the top 100 prescribers associated with those overrides. The reports shall also include the top 100 drugs associated with emergency or *Grier* Overrides as well as summary totals of overrides. The *Grier* Override reports shall be delivered to TennCare in electronic format and hardcopy, as described by TennCare. The reports shall be due on the fifteenth (15th) day of the month for the previous month's POS pharmacy claims override activity.

Failure by the Contractor to provide emergency or *Grier* Override Aggregate Reports listed above in a complete and timely manner may result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day for the second consecutive month violations are identified. TennCare will monitor *Grier* Override Aggregate Reports and notify the Contractor of any violations as well as any possible sanctions related to those violations. The Contractor will have seventy-two (72) hours, following written notification, to correct all violations prior to assessment of

liquidated damages by TennCare. The Contractor shall submit to TennCare, within twenty-four (24) hours, a corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

In the event the *Grier* Revised Consent Decree is modified through a court order, the Contractor may be required to adjust the number of days supply that should be processed in these emergency situations. TennCare will notify the Contractor via certified mail and email when any changes occur and advise the Contractor of the effective date of any changes.

A.16. Emergency or *Grier* Override Aggregate Interventions and Prior Authorization Operations

The Contractor will monitor, on a weekly basis, all emergency or *Grier* Overrides performed by dispensing pharmacists at the point-of-sale, pursuant to the policy regarding dispensing of drugs not listed on the TennCare PDL and identify the top 100 prescribers of non-preferred drugs that were filled during the previous week. Between Monday and Friday of the following week, the Contractor will attempt to contact each of the top 100 prescribers (or their duly authorized agents) via telephone and if contact is made, discuss with the prescriber PDL compliance. While this process with the prescriber is not member specific, the Contractor will attempt to discuss all therapeutic categories of non-compliance and explain to the prescriber TennCare PDL alternatives and the prior authorization process.

Failure by the Contractor to attempt to contact 100% of the top 100 prescribers identified each week as having written prescriptions for a non-preferred drug that resulted in an emergency supply dispensed by a pharmacy provider may result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day for the first month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day for the second consecutive month violations are identified. TennCare will monitor the Contractor's call logs and notify the Contractor of any violations, as well as any possible sanctions related to those violations. The Contractor will have seventy-two (72) hours following written notification to correct all violations prior to the assessment of liquidated damages by TennCare. The Contractor shall submit to TennCare, within twenty-four (24) hours, a written corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

In the event any prescriber is identified by the Contractor as non-compliant for three weeks out of any consecutive four-week period, the Contractor will provide that information to TennCare and the MCOs for whom the prescriber is a network provider.

The Contractor will provide TennCare with a monthly report of compliance with the PDL that is pharmacy specific. The report shall illustrate PDL-compliant dispensing patterns of every pharmacy provider in increments of five (5) percentage points and ranked from the highest compliance rates to the lowest, inclusive of all pharmacy providers. PDL compliance rates and these monthly reports apply only to the therapeutic categories covered under the TennCare PDL. The Contractor must submit this monthly report to TennCare, on or before the fifteenth day after each calendar quarter.

Failure by the Contractor to provide the monthly report of PDL compliance by pharmacy providers as described above result in the assessment of liquidated damages by TennCare of five hundred dollars ($500) per month during the first month violations are identified. Liquidated damages will increase to one thousand dollars ($1,000) per month for the second consecutive month violations are identified. TennCare will review the *Grier* Override reports and notify the Contractor of any violations of the requirements as well as any possible sanctions related to those violations. The Contractor will have seventy-two (72) hours, following written notification, to correct all violations prior to the assessment of liquidated damages by TennCare. The Contractor shall submit to

TennCare, within twenty-four (24) hours, a written corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

The Contractor must report monthly to TennCare, on or before the fifteenth day of the following month, all activity associated with *Grier* Override Interventions. These reports shall include logs of calls made to prescribers and the outcomes of those calls.

Failure by the Contractor to provide the *Grier* Override Intervention reports listed above in a complete and timely manner may result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day for the second consecutive month violations are identified. TennCare will review the *Grier* Override Intervention reports and notify the Contractor of any violations of the requirements as well as any possible sanctions related to those violations. The Contractor will have seventy-two (72) hours, following written notification, to correct all violations prior to assessment of liquidated damages by TennCare. The Contractor shall submit to TennCare, within twenty-four (24) hours, a written corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

In the event the *Grier* Revised Consent Decree is modified through a court order, the Contractor may be required to adjust the number of days supply that should be processed in these emergency situations. TennCare will notify the Contractor via certified mail and email when any changes occur and advise the Contractor of the effective date of any changes.

A.17. Prior Authorizations for drugs and products not on the TennCare PDL

The Contractor will be required to perform all of the prior authorization processes described in this contract for certain drugs that are not in the categories of drugs specified in the TennCare PDL. For example, TennCare may require prior authorization for a drug that is in a therapeutic category with no competitors and utilization is minimal (i.e. an orphan drug). TennCare will also require prior authorization processes be completed by the Contractor for specialty pharmacy drugs and services and for drugs and products in therapeutic categories not normally covered by TennCare.

B. CONTRACT TERM:

B.1. Contract Term. This Contract shall be effective for the period commencing on January 1, 2004, and ending on December 31, 2006. The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period.

B.2. Term Extension. The State reserves the right to extend this Contract for an additional period or periods of time representing increments of no more than one year and a total contract term of no more than five (5) years, provided that the State notifies the Contractor in writing of its intention to do so at least thirty (30) days prior to the contract expiration date. An extension of the term of this Contract will be effected through an amendment to the Contract. If the extension of the Contract necessitates additional funding beyond that which was included in the original Contract, the increase in the State's maximum liability will also be effected through an amendment to the Contract and shall be based upon rates provided for in the original contract.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Fourteen Million One Hundred Ninety-Three Thousand Dollars ($14,193,000.00). The Service Rates in

Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The Service Rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the Service Rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

C.2. Compensation Firm. The Service Rates and the Maximum Liability of the State under this Contract are firm for the duration of the Contract and are not subject to escalation for any reason unless amended. It is expected that the number of monthly claims transactions will average 3,159,2000 (as referenced in the RFP**).** By agreement of both parties, should the amount of paid claims processed exceed 4,000,000 per month for three consecutive months or fall below 3,000,000 per month for three consecutive months, either party may request in writing that the comprehensive monthly fee in effect be renegotiated.

If the parties reach an agreement regarding a renegotiated comprehensive monthly fee for the remaining portion of the current calendar year, said agreement shall become effective by means of a contract amendment. Any such amendment must be mutually agreed upon by the parties and signed by the Contractor and the head of the procuring state agency and must be approved by other State officials as required by State laws and regulations.

C.3. Payment Methodology. The Contractor shall be compensated based on the Service Rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1. The Contractor's compensation shall be contingent upon the satisfactory completion of units of service or project milestones defined in Section A. The Contractor shall be compensated based upon the following Service Rates:

Comprehensive Monthly Fee Year 1	$484,500.00
Comprehensive Monthly Fee Year 2	$346,750.00
Comprehensive Monthly Fee Year 3	$351,500.00
Comprehensive Monthly Fee Year 4 (if renewed by amendment)	$356,250.00
Comprehensive Monthly Fee Year 5 (if renewed by amendment)	$361,000.00

The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall at a minimum, include: the numbers and types of pharmacy claims adjudicated; separately itemized actual payments made to pharmacy service providers for each pharmacy claim adjudicated; subtotal for all pharmacy claims adjudicated;

subtotal of all actual payments; the comprehensive monthly fee in effect, and the total amount due to the Contractor for the period invoiced.

C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

C.5. Payment of Invoice. The payment of the invoice by the State shall not prejudice the State's right to object to or question any invoice or matter in relation thereto. Such payment by the State shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

C.6. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the State, on the basis of audits conducted in accordance with the terms of this contract, not to constitute proper remuneration for compensable services.

C.7. Deductions. The State reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the Contractor.

C.8. Automatic Deposits. The Contractor shall complete and sign an "Authorization Agreement for Automatic Deposit (ACH Credits) Form." This form shall be provided to the Contractor by the State. Once this form has been completed and submitted to the State by the Contractor all payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee shall be made by Automated Clearing House (ACH). The Contractor shall not invoice the State for services until the Contractor has completed this form and submitted it to the State.

C.9. Retention of Final Payment. At the expiration of this Contract, or if at any time the state or Contractor should terminate this Contract, the Contractor will cooperate with any subsequent Contractor who might assume operation of the TennCare pharmacy program. TennCare will withhold final payment to the Contractor until transition to the new Contractor is complete.

D. STANDARD TERMS AND CONDITIONS:

D.1. Required Approvals. The State is not bound by this Contract until it is approved by the appropriate State officials in accordance with applicable Tennessee State laws and regulations.

D.2. Modification and Amendment. This Contract may be modified only by a written amendment executed by all parties hereto and approved by the appropriate Tennessee State officials in accordance with applicable Tennessee State laws and regulations.

D.3. Termination for Convenience. The State may terminate this Contract without cause for any reason. Said termination shall not be deemed a Breach of Contract by the State. The State shall give the Contractor at least sixty (60) days written notice before the effective termination date. The Contractor shall be entitled to receive compensation for satisfactory, authorized service completed as of the termination date, but in no event shall the State be liable to the Contractor for compensation for any service which has not been rendered. Upon such termination, the Contractor shall have no right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

D.4. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor violates any terms of this Contract, the State shall have the right to immediately terminate the Contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor.

D.5. Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, they shall contain, at a minimum, sections of this Contract pertaining to "Conflicts of Interest" and "Nondiscrimination" (sections D.6. and D.7.). Notwithstanding any use of approved subcontractors, the Contractor shall be the prime contractor and shall be responsible for all work performed.

D.6. Conflicts of Interest. The Contractor warrants that no part of the total Contract Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed relative to this Contract.

D.7. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Contractor shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.8. Records. The Contractor shall maintain documentation for all charges against the State under this Contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this contract, shall be maintained for a period of five (5) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.9. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.10. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.11. Strict Performance. Failure by any party to this Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.

D.12. Independent Contractor. The parties hereto, in the performance of this Contract, shall not act as employees, partners, joint venturers, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Contract shall be construed to create an employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.

The Contractor, being an independent contractor and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the Contractor's employees, and to pay all applicable taxes incident to this Contract.

D.13. State Liability. The State shall have no liability except as specifically provided in this Contract.

D.14. Force Majeure. The obligations of the parties to this contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, acts of God, riots, wars, strikes, epidemics or any other similar cause.

D.15. State and Federal Compliance. The Contractor shall comply with all applicable State and Federal laws and regulations in the performance of this Contract.

D.16. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Contractor agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract. The Contractor acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising therefrom, shall be subject to and limited to those rights and remedies, if any, available under ***Tennessee Code Annotated***, Sections 9-8-101 through 9-8-407.

D.17. Completeness. This Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.

D.18. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Contract are declared severable.

D.19. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

E. SPECIAL TERMS AND CONDITIONS:

E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, these special terms and conditions shall control.

E.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below or to such other party, facsimile number, or address as may be hereafter specified by written notice.

The State:
Deputy Commissioner
Department of Finance and Administration
TennCare Program
729 Church Street
Nashville, TN 37247
(615) 741-0043
(615) 532-3479 Fax

The Contractor:
Teresa R. DiMarco, President
First Health Services Corporation
4300 Cox Road

Glen Allen, VA 23060
(804) 965-7400 (Phone)

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the day of delivery; as of the date specified for overnight courier service delivery; as of three (3)business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the telefax machine at the receiving location and receipt is verbally confirmed by the sender if prior to 4:30 p.m. CST. Any communication by facsimile transmission shall also be sent by United States mail on the same date of the facsimile transmission.

E.3. Subject to Funds Availability. The Contract is subject to the appropriation and availability of State and/or Federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate the Contract upon written notice to the Contractor. Said termination shall not be deemed a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the Contract. Should such an event occur, the Contractor shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Upon such termination, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.4. Breach. A party shall be deemed to have breached the Contract if any of the following occurs:

— failure to perform in accordance with any term or provision of the Contract;
— partial performance of any term or provision of the Contract;
— any act prohibited or restricted by the Contract, or
— violation of any warranty.

For purposes of this contract, these items shall hereinafter be referred to as a “Breach.”

a. Contractor Breach— The State shall notify Contractor in writing of a Breach.

(1) In event of a Breach by Contractor, the state shall have available the remedy of Actual Damages and any other remedy available at law or equity.

(2) Partial Default— In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of: (1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State will begin to provide the service associated with the Breach. Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor.

In the event the State declares a Partial Default, the State may withhold, together with any other damages associated with the Breach, from the amounts due the Contractor the greater of: (1) amounts which would be paid the Contractor to provide the defaulted service; or (2) the cost to the State of providing the defaulted service, whether said service is provided by the State or a third party. To determine the amount the Contractor is being paid for any particular service, the Department shall be entitled to receive within five (5) days any requested material from Contractor. The State shall make the final and binding determination of said amount.

The State may assess Liquidated Damages against the Contractor for any failure to perform which ultimately results in a Partial Default with

said Liquidated Damages to cease when said Partial Default is effective (see Attachment A). Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor agrees to cooperate fully with the State in the event a Partial Default is taken. The amount of these liquidated damages assessed against the Contractor shall be at the discretion of the State not to exceed twenty-five (25) thousand dollars ($25,000.000).

(3) Contract Termination— In the event of a Breach, the State may terminate the Contract immediately or in stages. The Contractor shall be notified of the termination in writing by the State. Said notice shall hereinafter be referred to as Termination Notice. The Termination Notice may specify either that the termination is to be effective immediately, on a date certain in the future, or that the Contractor shall cease operations under this Contract in stages. In the event of a termination, the State may withhold any amounts which may be due Contractor without waiver of any other remedy or damages available to the State at law or at equity. The Contractor shall be liable to the State for any and all damages incurred by the State and any and all expenses incurred by the State which exceed the amount the State would have paid Contractor under this Contract. Contractor agrees to cooperate with the State in the event of a Contract Termination or Partial Takeover.

b. State Breach— In the event of a Breach of contract by the State, the Contractor shall notify the State in writing within 30 days of any Breach of contract by the State. Said notice shall contain a description of the Breach. Failure by the Contractor to provide said written notice shall operate as an absolute waiver by the Contractor of the State's Breach. In no event shall any Breach on the part of the State excuse the Contractor from full performance under this Contract. In the event of Breach by the State, the Contractor may avail itself of any remedy at law in the forum with appropriate jurisdiction; provided, however, failure by the Contractor to give the State written notice and opportunity to cure as described herein operates as a waiver of the State's Breach. Failure by the Contractor to file a claim before the appropriate forum in Tennessee with jurisdiction to hear such claim within one (1) year of the written notice of Breach shall operate as a waiver of said claim in its entirety. It is agreed by the parties this provision establishes a contractual period of limitations for any claim brought by the Contractor.

E.5. Partial Takeover. The State may, at its convenience and without cause, exercise a partial takeover of any service which the Contractor is obligated to perform under this Contract, including but not limited to any service which is the subject of a subcontract between Contractor and a third party, although the Contractor is not in Breach (hereinafter referred to as "Partial Takeover"). Said Partial Takeover shall not be deemed a Breach of Contract by the State. Contractor shall be given at least 30 days prior written notice of said Partial Takeover with said notice to specify the area(s) of service the State will assume and the date of said assumption. Any Partial Takeover by the State shall not alter in any way Contractor's other obligations under this Contract. The State may withhold from amounts due the Contractor the amount the Contractor would have been paid to deliver the service as determined by the State. The amounts shall be withheld effective as of the date the State assumes the service. Upon Partial Takeover, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.6. Performance Bond. Upon approval of the Contract by all appropriate State officials in accordance with applicable State laws and regulations, the Contractor shall furnish a

performance bond in the amount equal to two million ($2,000,000.00), guaranteeing full and faithful performance of all undertakings and obligations under this Contract for the initial Contract term and all extensions thereof. The bond shall be in the manner and form prescribed by the State and must be issued through a company licensed to issue such a bond in the State of Tennessee.

E.7. State Furnished Property. The Contractor shall be responsible for the correct use, maintenance, and protection of all articles of nonexpendable, tangible, personal property furnished by the State for the Contractor's temporary use under this Contract. Upon termination of this Contract, all property furnished shall be returned to the State in good order and condition as when received, reasonable use and wear thereof excepted. Should the property be destroyed, lost, or stolen, the Contractor shall be responsible to the State for the residual value of the property at the time of loss.

E.8. Incorporation of Additional Documents. Included in this Contract by reference are the following documents:

a. The Contract document and its attachments
b. All Clarifications and addenda made to the Contractor's Proposal
c. The Request for Proposal and its associated amendments
d. Technical Specifications provided to the Contractor
e. The Contractor's Proposal

In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these documents shall govern in order of precedence detailed above.

E.9. Lobbying. The Contractor certifies, to the best of its knowledge and belief, that:

No federally appropriated funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, and entering into any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

The Contractor shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including sub-grants, subcontracts, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients of federally appropriated funds shall certify and disclose accordingly.

E.10. Prohibited Advertising. The Contractor shall not refer to this Contract or the Contractor's relationship with the State hereunder in commercial advertising in such a manner as to state or imply that the Contractor or the Contractor's services are endorsed.

E.11. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be

regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

The Contractor's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this Contract; previously possessed by the Contractor without written obligations to the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure. Nothing in this paragraph shall permit Contractor to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been disclosed or made available to the Contractor due to intentional or negligent actions or inactions of agents of the State or third parties.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Contract.

E.12 HIPAA Compliance. Contractor warrants to the State that it is familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this contract. Contractor warrants that it will cooperate with the State in the course of performance of the contract so that both parties will be in compliance with HIPAA, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations. Contractor will sign any documents that are reasonably necessary to keep the State and Contractor in compliance with HIPAA, including but not limited to business associate agreements.

E.13. Copyrights and Patents. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims or suits which may be brought against the State for infringement of any laws regarding patents or copyrights which may arise from the Contractor's performance of this Contract. In any such action brought against the State, the Contractor shall satisfy and indemnify the State for the amount of any final judgment for infringement. The Contractor further agrees it shall be liable for the reasonable fees of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the Contractor to the State. The State shall give the Contractor written notice of any such claim or suit and full right and opportunity to conduct the Contractor's own defense thereof.

E.14. Environmental Tobacco Smoke. Pursuant to the provisions of the federal "Pro-Children Act of 1994" and the Tennessee "Children's Act for Clean Indoor Air of 1995," the Contractor shall prohibit smoking of tobacco products within any indoor premises in which services are provided pursuant to this Contract to individuals under the age of eighteen (18) years. The Contractor shall post "no smoking" signs in appropriate, permanent sites within such premises. This prohibition shall be applicable during all hours, not just the hours in which children are present. Violators of the prohibition may be subject to civil penalties and fines. This prohibition shall apply to and be made part of any subcontract related to this Contract.

E.15. Date/Time Hold Harmless. As required by ***Tennessee Code Annotated***, Section 12-4-118, the contractor shall hold harmless and indemnify the State of Tennessee; its officers and employees; and any agency or political subdivision of the State for any breach of contract caused directly or indirectly by the failure of computer software or any device

containing a computer processor to accurately or properly recognize, calculate, display, sort or otherwise process dates or times.

E.16. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the Contractor to the State.

In the event of any such suit or claim, the Contractor shall give the State immediate notice thereof and shall provide all assistance required by the State in the State's defense. The State shall give the Contractor written notice of any such claim or suit, and the Contractor shall have full right and obligation to conduct the Contractor's own defense thereof. Nothing contained herein shall be deemed to accord to the Contractor, through its attorney(s), the right to represent the State of Tennessee in any legal matter, such rights being governed by ***Tennessee Code Annotated***, Section 8-6-106.

E.17. Debarment and Suspension.

To the best of its knowledge and belief, the Contractor certifies by its signature to this Contract that the Contractor and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or State department or Contractor;
b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining attempting to obtain, or performing a public (federal, State, or Local) transaction or grant under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, State, or Local) with commission of any of the offenses detailed in section b. of this certification; and
d. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, State, or Local) terminated for cause or default.

The Contractors signature on the contract shall serve as certification of compliance with this policy. If any doubt exists, officials may check a list maintained by the General Services Administration which lists persons who have been debarred, suspended or proposed for debarment under 45 CRF Part 76 or 48 CFR Part 9, Subpart 9.4. The list can be found at: http://epls.arnet.gov/

If a person is debarred, suspended or proposed for debarment during the term of the Contract or if the State determines that an agency has misrepresented its status, a decision as to the type of termination action, if any, will be made after a thorough review to ensure the propriety of the proposed action. In this event, the Contract will not be renewed or extended (other than no-cost time extensions).

E.18. Fraud and Abuse

Pursuant to Executive Order 47 and 42 CFR § 1007, the Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the State Medicaid program (TennCare).

The TennCare Program Integrity Unit is responsible for assisting TBI MFCU with provider cases and has the primary responsibility to investigate TennCare enrollee fraud and abuse.

The Contractor shall immediately report to the TBI MFCU any known or suspected fraud and/or abuse, including, but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return monies allowed or paid on claims known to be false or fraudulent. The Contractor shall not investigate or resolve the suspicion, knowledge or action without informing the TBI MFCU, and shall cooperate fully in any investigation by the TBI MFCU or subsequent legal action that may result from such an investigation. The Contractor and health care providers, whether participating or non-participating providers, shall, upon request and as required by TennCare or state and/or federal law, make available to the TBI MFCU any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU shall, as required by TennCare or state and/or federal law, be allowed access to the place of business and to all TennCare records of any Contractor or health care provider, whether participating or non-participating, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU.

The Contractor shall report TennCare enrollee fraud and abuse to the TennCare Program Integrity Unit. The Contractor may be asked to help and assist in investigations by providing requested information and access to records. The Contractor and health care providers, whether participating or non-participating providers, shall, upon request and as required by TennCare or state and/or federal law, make available any and all supporting documentation/records relating to delivery of items or services for which TennCare monies are expended. Shall the need arise, the TennCare Program Integrity Unit shall be allowed access to the place of business and to all TennCare records of any TennCare Contractor or health care provider, whether participating or non-participating, during normal business hours, as required by TennCare or state and/or federal law.

E.18.1. Prevention/Detection of Provider Fraud and Abuse

The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

The Contractor shall provide monthly reports to TennCare that describe pharmacy provider dispensing patterns that statistically identify the pharmacy as an outlier that may be representative of potential fraudulent, abusive or wasteful dispensing patterns. Additionally, the Contractor will provide specific recommendations to TennCare, via a plan of correction that will eliminate the potentially fraudulent, abusive or wasteful dispensing patterns of these specific pharmacy providers. The reports shall be due on the fifteenth (15th) day of the month for the previous month's pharmacy claims.

Failure by the Contractor to provide the monthly reports listed above in a complete and timely manner may result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day for the second consecutive month violations are identified. TennCare will monitor the delivery and content of these reports and notify the Contractor of any violations as well as any possible sanctions related to those violations. The Contractor will have thirty (30) calendar days, following written notification, to correct all violations prior to assessment of liquidated damages by TennCare. The Contractor shall submit to TennCare, within five (5) business days, a corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

E.18.2. Fraud and Abuse Compliance Plan

The Contractor shall have a written Fraud and Abuse compliance plan. A paper and electronic copy of the plan shall be provided to the TennCare Program Integrity Unit. The Contractor's specific internal controls and polices and procedures shall be described in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the TennCare Program Integrity Unit within ninety (90) days of the effective date of this Agreement. The TennCare Program Integrity Unit shall provide notice of approval, denial, or modification to the Contractor within thirty (30) days of review. The Contractor shall make any requested updates or modifications available for review to TennCare and/or the TennCare Program Integrity Unit as requested by TennCare and/or the TennCare Program Integrity Unit within thirty (30) days of a request. The State shall not transfer their law enforcement functions to the Contractor. At a minimum the written plan shall:

i. Ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's fraud and abuse compliance plan;

ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract:

iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:

Claims edits;
Post-processing review of claims;
Provider profiling and credentialing;
Prior authorization;
Utilization management;
Relevant subcontractor and provider agreement provisions;
Written provider and enrollee material regarding fraud and abuse referrals.

iv. Contain provisions for the confidential reporting of plan violations to the designated person as described in item E.18.4. below;

v. Contain provisions for the investigation and follow-up of any compliance plan reports;

vi. Ensure that the identities of individuals reporting violations of the plan are protected;

vii. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;

viii. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU (Medicaid Fraud Control Unit) and that enrollee fraud and abuse be reported to the TennCare Program Integrity Unit;

ix. Ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.

E.18.3. The Contractor shall comply with the applicable requirements of the Model Compliance Plan for HMOs when the final model plan is issued by the U.S. Department of Health and Human Services, the Office of Inspector General (OIG).

E.18.4. The Contractor shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

E.18.5. The Contractor shall submit an annual report to the TennCare Program Integrity Unit that includes summary results of fraud and abuse tests performed as required by E.18.2.iii. and detailed in the Contractor's Fraud and Abuse compliance plan. The report should cover results for the year ending June 30 and be submitted by September 30 each year. This information in this report shall be provided in accordance with and in a format as described in the Contractor's approved compliance plan.

E.19. Failure to Meet Agreement Requirements

It is acknowledged by TennCare and the Contractor that in the event of failure to meet the requirements provided in this Contract and all documents incorporated herein, TennCare will be harmed. The actual damages which TennCare will sustain in the event of and by reason of such failure are uncertain, are extremely difficult and impractical to ascertain and determine. The parties therefore acknowledge that the Contractor shall be subject to damages and/or sanctions as described in Section A of this Contract. It is further agreed that the Contractor shall pay TennCare liquidated damages as directed by TennCare and not to exceed the fixed amount as stated in Section A of this Contract and identified in Attachment A of the *pro forma* contract; provided however, that if it is finally determined that the Contractor would have been able to meet the Contract requirements listed in Section A of this Contract but for TennCare's failure to perform as provided in this Contract, the Contractor shall not be liable for damages resulting directly therefrom.

IN WITNESS WHEREOF:

FIRST HEALTH SERVICES CORPORATION:

Teresa R. DiMarco, President **Date**

DEPARTMENT OF FINANCE AND ADMINISTRATION, TENNCARE BUREAU

M. D. Goetz, Jr., Commissioner **Date**

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr., Commissioner **Date**

COMPTROLLER OF THE TREASURY:

John G. Morgan, Comptroller of the Treasury **Date**

ATTACHMENT A

LIQUIDATED DAMAGES FOR PERFORMANCE MEASURES

PERFORMANCE MEASURE	REPORTING REQUIREMENT	REPORTING FREQUENCY	PENALTY
A.2.2.2.e. Assistance in Generating Quarterly Drug Rebate Invoices	The Contractor will assist TennCare in generating Medicaid quarterly drug rebate invoices by providing the designated TennCare staff monthly encounter data files that contain the specific information and in the specified format required by TennCare. These monthly encounter data files will be provided to TennCare no later than the fifteenth (15th) day of the following month.	Monthly before the 15th day of the month for the previous month's data	Two thousand dollars ($2,000.00) may be assessed for the first month of any failure to meet this requirement and four thousand dollars ($4,000.00) will be assessed for each violation of this requirement in consecutive subsequent months.
A.2.2.2.f. Drug Rebate Dispute Data	The Contractor must provide to the agency or business of the state's choosing, in a format described by TennCare, any and all appropriate pharmacy level claims data needed to resolve or avoid any Medicaid or supplemental drug rebate disputes.	This data must be provided to TennCare within fifteen (15) days of a request by TennCare	Two thousand dollars ($2,000.00) may be assessed for failure to meet this requirement and four thousand dollars ($4,000.00) will be assessed for each violation of this requirement in consecutive subsequent months.

A.2.2.2.g.i. Batch Electronic Media (EMC) Claims Processing	The Contractor must receive claims in electronic format, separate tape from diskette, convert diskette to tape, schedule tapes for immediate processing and return media to submitting providers within seventy-two (72) hours. The Contractor will assign identification control numbers to all batch claims within twenty-four (24) hours of receipt. The Contractor will maintain electronic backup of batch claims for the duration of the contract. If TennCare requests copies of batch electronic claims, these must be provided within twenty-four (24) hours of request. Electronic batch claims will be submitted through a sequential terminal, or similar method that will allow batch and POS claims to be adjudicated through the same processing logic.	Return media to submitting providers within seventy-two (72) hours of receipt, assignment of identification control numbers to all batch claims within twenty-four (24) hours of receipt and provide TennCare with copies of batch electronic claims within twenty-four (24) hours of request.	Two thousand dollars ($2,000.00) may be assessed for failure to meet this requirement and four thousand dollars ($4,000.00) will be assessed for each violation of this requirement in consecutive subsequent months.
A.2.2.2.g.ii. POS Claims	The Contractor will process POS pharmacy claims within five (5) seconds. This is the time from when the claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor and will include all procedures required to complete claim adjudication.	Five (5) seconds per processed pharmacy claim through the Contractor's POS system	Two thousand dollars ($2,000.00) may be assessed for failure to meet this systemic requirement and four thousand dollars ($4,000.00) will be assessed for a violation of this requirement in consecutive subsequent months.

A.2.2.2.g.iii. Paper Claims	Paper claims may include, but not be limited to, those submitted in situations when an enrollee has to visit an out-of-state pharmacy in an emergency or paper claims from any of the Tennessee Department of Health clinics. Paper claims will be submitted on universal claim forms. The Contractor will process and adjudicate these universal, paper claims within twenty (20) days of receipt. The Contractor will add all pertinent drug information data to the TennCare-POS system and DUR system immediately upon processing the claim.	Paper claims must be processed within twenty (20) days of receipt	Two thousand dollars ($2,000.00) may be assessed for failure to meet this systemic requirement and four thousand dollars ($4,000.00) will be assessed for a violation of this requirement in consecutive subsequent months.
A.2.2.2.h. POS Transaction and Downtime Statistics	The Contractor will provide TennCare with TennCare-POS statistics of transactions between the “switches” and the Contractor and statistics of any and all downtime associated with the Contractor’s pharmacy claims processing system. Transaction reports will include: volume, longest response time and average response time. Statistics will be provided to TennCare within ten (10) business days following the end of each calendar month.	Reports are due to TennCare ten (10) business days following the end of the reporting month.	Two thousand dollars ($2,000.00) may be assessed for failure to meet this systemic requirement and four thousand dollars ($4,000.00) will be assessed for a violation of this requirement in consecutive subsequent months.

A.3.5.1. Provision of all Prior Authorization Call Center toll-free telephone and facsimile numbers, as well as the appropriate mailing address for prior authorization requests	The Contractor will provide TennCare with all Prior Authorization Call Center toll-free telephone and facsimile numbers, as well as the appropriate mailing address for prior authorization requests, prior to December 15, 2003. The Contractor will also distribute these numbers to providers at all training and provider education sessions.	Required information is due to TennCare on or before December 15, 2003	One thousand dollars ($1,000.00) per day until this requirement is satisfied.
A.3.5.2. Prior Authorization Call Center Standards	The Contractor is responsible for meeting the following performance standards and is required to provide reports demonstrating that it has performed as follows: The Prior Authorization Call Center shall be available twenty-four (24) hours a day, seven (7) days a week, to respond to prior authorization requests, except for prior, written, TennCare-approved downtime. The Contractor shall provide sufficient staff, facilities, and technology such that ninety-five percent (95%) of all call line inquiry attempts are answered. Answer percentage rate shall be defined as (ACD calls)/ (ACD calls + Abandoned calls). The total number of abandoned calls shall not exceed five percent (5%) in any calendar month. Calls must be answered within thirty (30) seconds. If an automated voice response system is used as an initial response to inquiries, an option must exist that allows the caller to speak directly with an	Prior Authorization performance standards	One hundred dollars ($100) per day per performance standard during the first month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day per violation for the second consecutive month violations are identified.

	operator. The Contractor shall provide sufficient staff such that average wait time on hold per calendar month shall not be in excess of thirty (30) seconds. All call line inquiries that require a call back, including general inquiries, shall be returned within 1 business day of receipt one hundred percent (100%) of the time.		
A.3.5.3. Processing Prior Authorization requests received from prescribers via facsimile transmission and U.S. Mail	The Prior Authorization Call Center shall also process prior authorization requests from prescribers via facsimile transmission and U.S. Mail. These forms of requests shall also be responded to within twenty-four (24) hours of receipt one hundred percent (100%) of the time.	Prior Authorization requests must be responded to within twenty-four (24) hours of receipt	One hundred dollars ($100) per day during the first month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day per violation for the second consecutive month violations are identified.
A.3.5.4. Prior Authorization Call Center Reporting	Prior Authorization Call Center reporting shall be provided monthly, by the fifteenth (15th) day of the following month, and, at a minimum, shall include the following: a. Total hours of daily call center access provided, and any downtime experienced. b. Call abandonment rate, and average abandon time. c. Average answer speed in seconds. d. Comprehensive report on the nature of interventions requested, with counts of the twenty most frequent types of interventions handled during the month. e. Intervention volume by prescriber and pharmacy, with indication of the key	Prior Authorization Call Center reporting shall be provided monthly, by the fifteenth (15th) day of the following month	one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day for the second consecutive month violations are identified.

	types of interventions being received, including drug names and categories. f. Average ACD time of calls handled. g. Total number of intervention requests received. h. Total number of PA requests processed. i. Total number of PA requests approved. j. Total number of PA requests denied. k. Total number of intervention requests received via telephone. l. Total number of intervention requests received via facsimile. m. Total number of intervention requests received via U.S. Mail. n. Total number and types of complaints received from TennCare enrollees regarding any difficulties receiving pharmacy services under the TennCare Pharmacy Program.		
A.3.8. Post Implementation PDL Reports	The Contractor shall produce the following monthly reports in a format (such as MS Excel®) acceptable to TennCare: a. Monthly Cost Savings/Avoidance Report to include: utilization shifts by drug and drug class; cost savings resulting from changes in prescribing, by drug and drug class; compliance with TennCare PDL drug classes by prescribers; expenditure per claim comparison (monthly/quarterly/yearly). b. Quarterly evaluation of the effectiveness of the TennCare PDL and prior	The Contractor must submit the monthly Post Implementation PDL reports to TennCare, on or before the fifteenth day of the following month.	One hundred dollars ($100) per day during the first month until the reports are received and two hundred dollars ($200) per day for the second consecutive month the reports are late

	authorization programs, including recommendations for changes to TennCare PDL drugs, the criteria for review and approval of drugs, and protocols and procedures. c. Monthly Supplemental Rebate Negotiations Status Report on underway and completed, the status of negotiation outcomes and the product-specific financial impact of the supplemental rebates on the TennCare PDL. d. Quarterly report on supplemental rebate invoicing including calculations of the net cost of effected drugs to TennCare. e. Report on Total Estimated and Projected Future Savings from the TennCare PDL and prior authorization programs (monthly for the initial twelve (12) months of this contract and quarterly thereafter). f. Quarterly reports demonstrating the nature and extent of educational interventions to outlier prescribers, and the outcomes of those interventions.		
A.14. The Emergency Supply Override	The Contractor will assure that the TennCare-POS system allows pharmacists to execute an emergency override that will process an emergency supply of drugs in normally covered therapeutic categories that are not listed on the TennCare PDL. The Contractor's TennCare-POS system must post a message for the dispensing pharmacist to contact the prescriber and suggest alternative therapies listed on the TennCare PDL. Drugs eligible for the emergency override must be in	POS pharmacy claims processing performance standard	Two hundred dollars ($200) per day during the first month the override is not functioning and four hundred dollars ($400) per day for the second consecutive month any instances of an improperly functioning override is identified.

	a therapeutic class normally covered by TennCare. The Contractor will instruct pharmacy providers how to perform the emergency override in the National Council of Prescription Drug Programs (NCPDP) environment of the TennCare-POS pharmacy claims processing system.		
A.15. Emergency Override Aggregate Reports	The Contractor will provide TennCare with monthly emergency override aggregate reports that list the top 100 pharmacies entering emergency override and the top 100 prescribers associated with those overrides. The reports shall also include the top 100 drugs associated with emergency overrides as well as summary totals of overrides. The Emergency Override reports shall be delivered to TennCare in electronic format and hardcopy, as described by TennCare.	The reports shall be due on the fifteenth (15th) day of the month for the previous month's POS pharmacy claims override activity.	One hundred dollars ($100) per day the reports are late and two hundred dollars ($200) per day the reports are late for the second consecutive month
A.16. Emergency Override Aggregate Interventions and Prior Authorization Operations	The Contractor will monitor, on a weekly basis, all emergency override performed by dispensing pharmacists at the point-of-sale, pursuant to the policy regarding dispensing of drugs not listed on the TennCare PDL and identify the top 100 prescribers of non-preferred drugs that were filled during the previous week. Between Monday and Friday of the following week, the Contractor will attempt to contact each of the top 100 prescribers (or their duly authorized agents) via telephone and if contact is made, discuss with the prescriber PDL compliance. While this process with the prescriber is not member	Intervention Performance Standards	Failure by the Contractor to attempt to contact 100% of the top 100 prescribers identified each week as having written prescriptions for a non-preferred drug that resulted in an emergency supply dispensed by a pharmacy provider may result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day for the first month violations are identified.

	specific, the Contractor will attempt to discuss all therapeutic categories of non-compliance and explain to the prescriber TennCare PDL alternatives and the prior authorization process.		Liquidated damages will increase to two hundred dollars ($200) per day for the second consecutive month violations are identified.
A.16. Emergency Override Aggregate Interventions and Prior Authorization Operations	The Contractor will provide TennCare with a monthly report of compliance with the PDL that is pharmacy specific. The report shall illustrate PDL-compliant dispensing patterns of every pharmacy provider in increments of five (5) percentage points and ranked from the highest compliance rates to the lowest, inclusive of all pharmacy providers. PDL compliance rates and these monthly reports apply only to the therapeutic categories covered under the TennCare PDL. The Contractor must submit this monthly report to TennCare, on or before the fifteenth day after each calendar quarter.	Intervention Performance Standards	Failure by the Contractor to provide the monthly report of PDL compliance by pharmacy providers as described above result in the assessment of liquidated damages by TennCare of five hundred dollars ($500) per month during the first month violations are identified. Liquidated damages will increase to one thousand dollars ($1,000) per month for the second consecutive month violations are identified.
A.16. Emergency Override Aggregate Interventions and Prior Authorization Operations	The Contractor must report monthly to TennCare, on or before the fifteenth day of the following month, all activity associated with Emergency Override Interventions. These reports shall include logs of calls made to prescribers and the outcomes of those calls.	Intervention Performance Standards	Failure by the Contractor to provide the Emergency Override Intervention reports listed above in a complete and timely manner may result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first

			month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day for the second consecutive month violations are identified.
E.4.a.(2) Breach, Partial Default	In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of: (1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State will begin to provide the service associated with the Breach. Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor. In the event the State declares a Partial Default, the State may withhold, together with any other damages associated with the Breach, from the amounts due the Contractor the greater of: (1) amounts which would be paid the Contractor to provide the defaulted service; or (2) the cost to the State of providing the defaulted service, whether said service is provided by the State or a third party. To determine the amount the Contractor is being paid for any particular service, the Department shall be entitled to receive within five (5) days any requested material from Contractor. The State shall make the final and binding determination of said amount. The State may assess	Contract Performance Standard	The amount of these additional liquidated damages assessed against the Contractor shall be at the discretion of the State not to exceed twenty-five (25) thousand dollars ($25,000.000).

	Liquidated Damages against the Contractor for any failure to perform which ultimately results in a Partial Default with said Liquidated Damages to cease when said Partial Default is effective. Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor agrees to cooperate fully with the State in the event a Partial Default is taken.		